

FILED JAN 7 1946

1. PLACE OF DEATH:

(a) County **PETTIS**
(b) City or town **SEDALIA**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **BOTHWELL HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Mo.**
(Specify whether
In this community **30 yrs.**
years, months or days)

3. (a) PRINT FULL NAME **ROY JOHN HAUSAM**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **491-07-4279**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MAR.**
6. (b) Name of husband or wife **ROSE** 6. (c) Age of husband or wife if alive **45** years
7. Birth date of deceased **JULY 18 1884**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 5 5 hr. min.

9. Birthplace **CAMERON MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **MIDWEST AUTO STORES**

11. Industry or business **AUTO ACCESSORIES**

12. Name **JOHN HAUSAM**

13. Birthplace **KEOKUK IOWA**
(City, town, or county) (State or foreign country)

14. Maiden name **ELIZABETH FRECH**

15. Birthplace **N.Y. CITY N.Y.**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. R.J. HAUSAM**

(b) Address **SEDALIA RFD #4**

17. (a) **BURIAL** (b) Date thereof **12-26-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MEM. PARK**

18. (a) Signature of funeral director **Geo. Dillard**

(b) Address **Sedalia Mo**

19. (a) **12/26/45** (b) **W. G. Campbell**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **PETTIS**
(c) City or town **SEDALIA RURAL**
(If outside city or town limits, write "RURAL")
(d) Street No. **RFD #4**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC** day **23**
year **1945** hour **12** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **6-3**, 1941, to **12-23**, 1945.
that I last saw him alive on **12-22-**, 1945.
and that death occurred on the date and hour stated above.

Immediate cause of death **Thermia**

Due to **Nephrosclerosis**

Other conditions **Chronic myocarditis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **1310**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
Signature **J. M. Rodeman** (M. D. or other) **MD**
Address **Sedalia Mo** Date signed **12-25-45**

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
MISSOURI DEPARTMENT OF COMMERCE

RECEIVED

Strict Health Officer No. 8

Serial File Number

Date Filed 1-8-46

DEC 12 1945
MAR 15 1946

1. PLACE OF DEATH

(a) Name of hospital or institution, with location (If not in hospital or institution, with location)

(b) Length of stay: In hospital or institution

(c) Name of hospital or institution, with location (If not in hospital or institution, with location)

(d) City or town (If not in city or town, with location)

(e) County (If not in county, with location)

(f) State (If not in state, with location)

2. (a) PRINT FULL NAME

(b) If patient, name of

(c) If not patient, name of

3. (a) PRINT FULL NAME

(b) If patient, name of

(c) If not patient, name of

4. (a) Name of husband or wife

(b) Age of husband or wife

(c) Color or race

5. Birth date of deceased

(a) Year

(b) Month

(c) Day

6. (a) Name of husband or wife

(b) Age of husband or wife

(c) Color or race

7. (a) Name of husband or wife

(b) Age of husband or wife

(c) Color or race

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(c) Color or race

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(c) Color or race

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI DEPARTMENT OF COMMERCE - USE IN ADVANCING STOCK TAKING - A PERMANENT RECORD