WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT REC

COMMERCE
ENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

FILED JAN 11 1945

State File No. 42319

District No. 376 Primary Registration District No. 3061 Registrar's No. 267

**E OF DEATH:**

County St Francois 94

(b) City or town Flat River, Mo 1

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

3. (a) PRINT FULL NAME ALMAQUAN HAHN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race W

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Mar (Month) 23 (Day) 1943 (Year)

8. AGE: Years 2 Months 8 Days 8 If less than one day hr. min.

9. Birthplace Flat River, Mo. 0 (City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Leslie C. Hahn
13. Birthplace Alliance Mo. 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name May Slaugh
15. Birthplace Millerville Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant Leslie C. Hahn

(b) Address Flat River, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (Month) 4 (Day) 45 (Year)

(c) Place: burial or cremation Parkview

18. (a) Signature of funeral director Caldwell Bros.

(b) Address Flat River, Mo.

19. (a) 12-28-45 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

1517

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County St. Francois 94

(c) City or town Flat River 5

(If outside city or town limits, write "RURAL")

(d) Street No. 2

(If rural, give location)

(e) Citizen of foreign country? Mo. 0 (Yes or No)

If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 1 year 1945 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from Nov. 15, 1945 to Dec 1, 1945 that I last saw her alive on Nov 30, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Endocarditis | |
| Due to Influenza | 2 wks |
| Due to Congenital malformation of heart - Foramen ovale | |
| Other conditions failed to close (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy 33 b

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. W. Tuspan (M.D.) DO

Address Flat River Mo Date signed 12/11/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No.
District File Number
Date Filed

RECEIVED
District Health Officer No. 4
District File Number 146-1559
Date Filed 1-9-46

**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 ..... Registered Apprentice No. ..... working under my personal supervision.

Signed Geo. R. Caldwell

Licensed Embalmer No. 2531

P. O. Address Flat River Mo

**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.**