S. No. 2
0M—2-43
v. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 28 1945

State File No. 42414

Registration District No. 517 Primary Registration District No. 6676 Registrar's No. 2889

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Robert Koch Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 417 days (Specify whether
In this community 46 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4601 Newport 9
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JOSEPH HAICH

3. (b) If veteran, name war

3. (c) Social Security No. 488-05-6249

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Marie Reichardt Haich

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased 7 (Month) 9 (Day) 1877 (Year)

8. AGE: Years 68 Months 5 Days 9 If less than one day hr. min.

9. Birthplace (City, town, or county) Austria 11 (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name Fred Haich
13. Birthplace (City, town, or county) Austria 4 (State or foreign country)

MOTHER
14. Maiden name Marie Schwartz
15. Birthplace (City, town, or county) Austria 4 (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Old S S Peter & Paul

18. (a) Signature of funeral director Wacker-Helderle
(b) Address 3634 Gravois Ave

19. (a) 12-21-45 (Date received local registrar) (b) E. G. McGarran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 18 year 1945 hour 6 minute 30 A. M.

21. I hereby certify that I attended the deceased from 10-27- 1944, to 12-18 1945; that I last saw him alive on 12-18 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chr Pul Tb	?
Due to 13	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 B. Friedman (M. D. or other) M.D.
Address Koch Hosp, Koch, Mo. Date signed 12-18-45

(Licensed Embalmer's Statement on Reverse Side)

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. Robert C Wheeler

Licensed Embalmer No. 2128

P. O. Address. St Louis 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.