

**FILED** AUG 20 1946

Registration District No. 33

Primary Registration District No. 3010

Registrar's No. 275

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

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU

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

(c) Name of hospital or institution: ST. FRANCIS 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 HR (Specify whether years, months or days)

In this community 3 HR

3. (a) PRINT FULL NAME HAHN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE 0 5. Color or race WH 6. (a) Single, widowed, married, divorced  0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive  years

7. Birth date of deceased MAY 15TH 1946  
(Month) (Day) (Year)

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

9. Birthplace CAPE GIRARDEAU MO 0  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name HERBERT J. HAHN

13. Birthplace ORAN RFD MO 0  
(City, town, or county) (State or foreign country)

14. Maiden name VERNEDA POBST

15. Birthplace ORAN RFD MO 0  
(City, town, or county) (State or foreign country)

16. (a) Informant MOTHER

(b) Address CHAFFER RFD

17. (a) BURIAL (b) Date thereof MAY 16 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ORAN CATHOLIC CEM

18. (a) Signature of funeral director Heisserer Funeral Home

(b) Address Oran Mo.

19. (a) 8-16-1946 (b) C. C. Summers  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County SCOTT 100

(c) City or town CHAFFEE RFD Mo 0  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country?  (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 15  
year 1946 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 5/15/46 to 5/15/46, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Microcephalic Meningocele.  
Congenital Malformation

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy 157B

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) \_\_\_\_\_ (Specify type of place) \_\_\_\_\_

While at work?  (Specify type of place) \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

23. Signature A. B. Chad (M. D. or other) \_\_\_\_\_

Address Cape Girardeau Date signed 8-15-46

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. <sup>4</sup>.....  
District File Number 846-2517.....  
Date Filed 8-19-46.....

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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.....

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.**