# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

FILED AUG 10 1946

Do not use this space.

28316

File No. 1793

Registered No.

1. PLACE OF DEATH
County St. Louis
Township St. Ferdinand
City —
Registration District No. 317
Primary Registration District No. 6076
(No. ..... St. ..... Ward)

2. FULL NAME Joseph Haldenwanger
(a) Residence. No. R4-Box 473- Chambers Rd. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 28, 1946

7. AGE

| Years | Months | Days | If less than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| | | | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis County
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER Otto William Haldenwanger
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Dorothy Anne Beck
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Jennings,
(STATE OR COUNTRY) Mo

14. INFORMANT Otto W. Haldenwanger
(Address) R4-Box 473- Chambers Rd.

15. FILED Oct 10, 1946 Ruth Allen MD
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 28 1946

17. I HEREBY CERTIFY That I attended deceased from Aug 28, 1946, to Aug 28, 1946 that I last saw b... alive on Aug 28, 1946, and that death occurred, on the date stated above, at 7:35 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature Birth
(5 3/4 month)
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) —
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? — DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) Albert Wall, M. D
8/29, 1946 (Address) 5322 Helen

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery
DATE OF BURIAL 8/29 1946

20. UNDERTAKER Father of deceased.
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1793

**1. PLACE OF DEATH:**

(a) County St Louis

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

(c) Name of hospital or institution:
(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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

(c) City or town
(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

**3. (a) PRINT FULL NAME** Joseph Haldenwanger

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 28 (Day) 1946 (Year)

**8. AGE:** Years | Months | Days | If less than one day 1½ hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 10-10-46 (Date received local registrar) (b) Ruth J Allen MD (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Month Aug 28 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

28316