

No. 2
-12-45
5-17-39
X47070

23734

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 31 1947

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 169

1. PLACE OF DEATH

(a) County Cole

(b) City or town Jefferson City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 DAYS
(Specify whether years, months or days)

In this community 2 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole ²⁶

(c) City or town Jefferson City, Mo. ⁵
(If outside city or town limits, write "RURAL")

(d) Street No. 712 E. McCall St. ⁴
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Geneva V. Hauchens

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day June
year 1947 hour 10:30 minute A. M.

21. I hereby certify that I attended the deceased from Jan. 27 1947 to June 12 1947
that I last saw her alive on June 12 1947
and that death occurred on the date and hour stated above.

5. Color or race wh

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

4. Sex Female

6. (b) Name of husband or wife Ed Hauchens

6. (c) Age of husband or wife if alive 65 years 5 months 1883 (Day) (Year)

7. Birth date of deceased Dec (Month) 5 (Day) 1883 (Year)

Immediate cause of death Pulmonary Embolism ^{Duration}

Arterial Fibrillation

Due to Hypertensive Heart Disease

Other conditions (P)
(Include pregnancy within 3 months of death)

Major findings of operations P.O. Intestinal & abdominal wall

Of autopsy ad lesions

8. AGE: Years 63 Months 6 Days 7 If less than one day hr. _____ min. _____

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER

12. Name George - Kirobi

13. Birthplace N.S. (City, town, or county) (State or foreign country)

14. Maiden name Mary Spicer

15. Birthplace No Record (City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Arnold Smith

(b) Address Versailles Mo

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? _____

17. (a) Removal (b) Date thereof 6-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Versailles Mo

18. (a) Signature of funeral director W. F. Kewell

(b) Address Versailles Mo

While at work _____ (Specify type of place)

(e) Means of injury _____

19. (a) 7-29-47 (b) R. P. Harris M.D.
(Date received local registrar) (Registrar's signature)

23. Signature R. P. Harris (M. D. or other) M.D.

Address Jefferson City, Mo. Date signed 6/12/47

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 7-30-47

JUL 31 1947

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 *W. F. Hedwell*

Licensed Embalmer No. *1596*

P. O. Address *San Carlos*

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.