

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43034

State File No. \_\_\_\_\_

FILED DEC 22 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2868

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sherman</u> |  | c. CITY OR TOWN <u>Sherman</u> <u>474</u>   |  |
| c. LENGTH OF STAY (in this place) <u>30 yrs.</u>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>       |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Paul Rd.</u>                                 |  | e. STREET ADDRESS (If rural, give location) <u>St. Paul Rd.</u>   |  |

|                                     |                        |                         |                           |   |
|-------------------------------------|------------------------|-------------------------|---------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Carl</u> | b. (Middle) <u>John</u> | c. (Last) <u>Haussels</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 8 1955</u> |
|-------------------------------------|------------------------|-------------------------|---------------------------|---|

|                    |                               |   |                                      |   |                               |                                      |
|--------------------|-------------------------------|---|--------------------------------------|---|-------------------------------|--------------------------------------|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Sept 1, 1904</u> | 9. AGE (In years last birthday) <u>51</u> | IF UNDER 1 YEAR Days <u>9</u> | IF UNDER 24 HRS. Hours <u>1</u> Min. |
|--------------------|-------------------------------|---|--------------------------------------|---|-------------------------------|--------------------------------------|

|  |  |  |  |
|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Store</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Ellisville, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|--|--|--|--|

|   |                                      |   |
|---|--------------------------------------|---|
| 13a. FATHER'S NAME <u>P. Wm. Haussels</u> | 13b. MOTHER'S MAIDEN NAME <u>Unk</u> | 14. NAME OF HUSBAND OR WIFE <u>Bonnie Chambers Haussels</u> |
|---|--------------------------------------|---|

|   |  |  |                             |
|---|--|--|-----------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unk.</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Bonnie Haussels</u> | ADDRESS <u>Sherman, Mo.</u> |
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|---|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>20 min</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>   |  |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Angina pectoris</u><br>DUE TO (c) |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |   |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4201</u> |
|--|--|---|

|  |  |                            |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from June 30, 1955, to Dec 8, 1955, that I last saw the deceased alive on Dec 8, 1955, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

|   |                                |                                  |
|---|--------------------------------|----------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Henry F. Scott M.D.</u> | 23b. ADDRESS <u>Ballwin Mo</u> | 23c. DATE SIGNED <u>Dec 9-55</u> |
|---|--------------------------------|----------------------------------|

|   |                           |   |  |
|---|---------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>12-11-55</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN CEM.</u> | 24d. LOCATION (City, town, or county) (State) <u>ELLISVILLE, Mo.</u> |
|---|---------------------------|---|--|

|   |   |  |  |
|---|---|--|--|
| DATE REC'D BY LOCAL REG. <u>12-9-55</u> | REGISTRAR'S SIGNATURE <u>Herbert P. Dombard</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Schrader</u> | ADDRESS <u>Funeral Home Ballwin, Mo.</u> |
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Dr. (Licensed Embalmer's Statement on Reverse Side)

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

**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 ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Richard Bopp*

Licensed Embalmer No. *458*

P. O. Address *Ballwin, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.