

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10380

STATE FILE NUMBER

2151

FILED MAR 27 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

Health,  
& Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Macoupin</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Dorchester</b> <b>8/20/8</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Length of stay in lb <b>17 Days</b>	d. STREET ADDRESS (If outside, give location) <b>32</b> Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>JOHN</b> Last <b>HAUSCHILD</b>			4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1957</b>
5. SEX <b>Male</b> <input type="checkbox"/>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1902</b>
9. AGE (In years last birthday) <b>54</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Dorchester, Ill.</b>
13. FATHER'S NAME <b>John Hauschild</b>		14. MOTHER'S MAIDEN NAME <b>Mary Fahrncrow</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>330-16-8224</b>	17. INFORMANT Address <b>Clarence Hauschild, Gillespie, Ill.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Granuloma of lung, possibly due to fungus infection. ? Carcinoma of lung</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3-4 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>2/15/57</b> to <b>3/3/57</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>3/3/57</b> Death occurred at <b>1:10</b> A. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Edward H. Nasse M.D.</b> (Degree or title)		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>3/3/57</b>
23a. BURIAL, CREMATION, REMOVAL-(Specify) <b>Burial</b>	23b. DATE <b>305-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City</b>	23d. LOCATION (City, town, or county) (State) <b>Bunker Hill, Ill.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 4 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>

350-10-2211  
 Clarence M. Schmitt, M.D.  
 St. Louis, Mo.  
 1948

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 Elton H. Remelius

Licensed Embalmer No. 428

P. O. Address St. Louis

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.