

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH'57 02 2250
State File No.

BIRTH NO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. <u>173</u>	
1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>ST. CHARLES</u>		c. LENGTH OF STAY (In this place) <u>2 Mos.</u>		c. CITY OR TOWN <u>ST. JAMES</u> ⁰⁸¹⁰ ₀		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>ST. CHARLES NURSING HOME</u>				e. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) <u>SAROLINE K HAKE</u>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH <u>JULY 7, 1957</u> (Month) (Day) (Year)	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JUNE 14, 1882</u>		9. AGE (In years last birthday) <u>75</u>	10. UNDER 1 YEAR <u>0</u>	11. UNDER 48 HRS. <u>23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IN OWN HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>HERBERT W. HAKE (DECEASED)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>URNADISSER, RR#1, ST. CHARLES, MO</u> ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Gallbladder with generalized metastases</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
	ANTECEDENT CAUSES _____						
	DUE TO (b) _____						
	DUE TO (c) _____						
	II. OTHER SIGNIFICANT CONDITIONS <u>None</u>						
	Conditions contributing to the death but not related to the disease or condition causing death. <u>155x</u>						
19a. DATE OF OPERATION <u>Feb. 26, 1957</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Gallbladder with metastases</u>				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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) _____			
21d. TIME OF INJURY _____ (Month) (Day) (Year) (Hour)		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 <u>Feb. 18, 1957</u> , to <u>July 7, 1957</u> , that I last saw the deceased alive on <u>July 7, 1957</u> , and that death occurred at <u>3:45 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Don L. Randall, M.D.</u>				23b. ADDRESS <u>207 N. 5th St. St. Charles, Mo.</u>		23c. DATE SIGNED <u>July 8, 1957</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>JULY 8, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ST. JAMES MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>July 8-57</u>		REGISTRAR'S SIGNATURE <u>Margaret Wilson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. L. Prinster</u> ADDRESS <u>St. Charles, Mo.</u>			

AUG 8 1957

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 *J. W. Binkley*.....
Licensed Embalmer No. *365*

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.