

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013752

STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 115-116 Primary Registration District No. 5433 Registrar's No. 131

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 causally 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 <b>FRANKLIN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>UNION</b> TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>LESLIE</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ON HIGHWAY</b>		Length of stay in 1b	d. STREET ADDRESS <b>R.R.</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BETTY</b> Middle <b>HAUCK</b> Last <b>HAUCK</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>1958</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 24, 1903</b>
9a. AGE (In years last birthday) <b>55</b>		9b. IF UNDER 1 YEAR Months <b>7</b> Days <b>24</b>	9c. IF UNDER 24 HRS. Hours <b>8</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>MILLINERY</b>	11. BIRTHPLACE (City and state or country) <b>HOLLY SPRINGS, MISS.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MATHEW LONG</b>	
14. MOTHER'S MAIDEN NAME <b>JANE ALICE MAYER</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>488-09-9887</b>		17. INFORMANT Address <b>NELL STROUPE, HOLLY SPRINGS, MISS.</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) <i>multiple fractures of rib cage with laceration of lung and of middle cerebral skull fracture</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>multiple fractures of rib cage</i> DUE TO (c) <i>with laceration of lung and of middle cerebral skull fracture</i>			
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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <i>Subject was passenger in auto</i>		
20c. TIME OF INJURY Hour <b>9:45</b> a. m. <b>4/15/58</b> Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>Eastern River Bridge</i>	20f. CITY, TOWN, OR LOCATION <i>Union</i>	COUNTY <b>Franklin</b> STATE <b>MO</b>
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>[Signature]</i>		22b. ADDRESS <i>Union Mo</i>	22c. DATE SIGNED <i>4/17/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4-18-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET BURIAL PARK</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>E. F. OLTMANN UNION, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>4/17/58</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

(Licensed Embalmer's Statement on Reverse Side)

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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..... *Ralph Ottmann*

Licensed Embalmer No. *480*

P. O. Address *Union*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.