

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034301

STATE FILE NUMBER

FILED OCT 3 1958

Registration District No. 318

Primary Registration District No. 1003

Registrar's 9150

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis, Mo</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>01 3654 Flad Home</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>179 3654 Flad Ave</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Henry Herman Hauhart</i>			4. DATE OF DEATH Month Day Year <i>9-23-58</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 13, 1877</i>	9. AGE (In years last birthday) <i>80</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carried Mail</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Mail Carrier</i>	11. BIRTHPLACE (City and state or country) <i>Manchester, Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Henry Herman Hauhart</i>			14. MOTHER'S MAIDEN NAME <i>Mary Schlueter</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	17. INFORMANT Address <i>Cecilia Shields 3654 Flad</i>			
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>Coronary Thrombosis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Phlebitis of Left Leg</i>					3 months	
DUE TO (c) <i>463x</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>	
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.) <i>MI</i>			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. <i>MI</i>						
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		STATE	
21. I attended the deceased from <i>11/19/57</i> to <i>9/23/58</i> and last saw ^{her} him alive on <i>9/16/58</i> Death occurred at <i>2:45 A.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>Bertie C. Hall M.D.</i>			22b. ADDRESS <i>3402 1/2 Lafayette</i>		22c. DATE SIGNED <i>9/23/58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<i>Burial</i>	<i>9-25-58</i>	<i>Oak Grove Cemetery</i>		<i>St. Louis County, Mo.</i>		
24. FUNERAL DIRECTOR ADDRESS <i>Weick Bros 2201 S. Grand Blvd</i>			25. DATE RECD. BY LOCAL REG. <i>SEP 23 1958</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i>		

(Licensed Embalmer's Statement on Reverse Side)

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

MEDICAL CERTIFICATION

Dr. Preston Shields.
2907 Lafayette

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 *V E Morris*.....

Licensed Embalmer No. *33*

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.