

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048394

FILED VS DEC 19 1966

STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 54

INDEXED

1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STR. GENEVIEVE</u> Length of stay in 1b <u>9 YRS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STR. GENEVIEVE REC. HOME</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY _____ c. CITY OR TOWN <u>ST LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>4100 FIRST ST PARK</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle _____ Last <u>HAUCK</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>10</u> Year <u>1966</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/65</u>	9. AGE (last birthday) <u>95</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
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 		11. BIRTHPLACE (City and state or country) <u>ZELL MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>LAWRENCE SUCHERT</u>			13b. MOTHER'S MAIDEN NAME <u>REGINA SUCHER</u>			14. NAME OF HUSBAND OR WIFE <u>CHARLES HAUCK</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [(If yes, give war or dates of service)] <u>NO</u>			16. SOCIAL SECURITY NO.			17. INFORMANT Address <u>FAMILY RECORD ZELL, MO.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____		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 <u>Dec. 7, 1966</u> to <u>Dec. 16, 1966</u> and last saw ^{her} <u>him</u> alive on <u>Dec. 7, 1966</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Dr. Lanning M.D.</u>				22b. ADDRESS <u>St. Genevieve Mo</u>		22c. DATE SIGNED <u>12/10/66</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12/13/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST JOSEPH</u>		23d. LOCATION (City, town, or county) (State) <u>PRARIE DU ROCHE ILL</u>		
24. FUNERAL DIRECTOR ADDRESS <u>DASHNER FUNERAL HOME</u>				25. DATE RECD. BY LOCAL REG. <u>Dec. 12, 1966</u>		26. REGISTRAR'S SIGNATURE <u>Knull Barber</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Leo C. Basler

Licensed Embalmer No. 1985

P. O. Address St. Vincent

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.