

MISSOURI DIVISION OF PUBLIC HEALTH AND WELFARE
 DEPARTMENT OF PUBLIC HEALTH AND WELFARE

REGISTRATION DISTRICT NO. 318 PRIMARY REGISTRATION DISTRICT NO. 1003 REGISTRAR'S NO. 10241 **-61-038641**
 STATE FILE NUMBER

DATE AMENDED
 AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

FILED NOV 10 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3847a Humphrey St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3847a Humphrey St.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Hach</u> Last <u>Hach</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/81</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lampert Cigar Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cigar</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George Hach</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Frank Hach</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT <u>Fred J. Hach - 3205 Hartford St.</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>Cancer Generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u>
DUE TO (b) <u>Cancer of Colon</u>		
DUE TO (c) <u>153.8</u>		

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 type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--

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 July 1956 to 11/2/61 and last saw him alive on 10/26/61
 Death occurred at 6:40 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Michael J. Powell M.D.</u>	22b. ADDRESS <u>4660 Mayland</u>	22c. DATE SIGNED <u>11/3/61</u>
---	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	23b. DATE <u>Nov. 6, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Mausoleum</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
--	----------------------------------	--	--

24. FUNERAL DIRECTOR <u>WACKER-HELDERLE - 3634 Gravois Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>NOV 3 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
--	---	--

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 Delit J. Krupin
Licensed Embalmer No. 3497
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.