

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

65-049044

Registration District No. 316 Primary Registration District No. 3259 Registrar's No. 534 STATE FILE NUMBER

FILED JAN 11 1966

1. PLACE OF DEATH a. COUNTY <u>ST FRANCIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. FRANCIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BONNE TERRE</u>		c. CITY OR TOWN <u>FLAT RIVER, MO</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BONNE TERRE HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>811 MONROE ST.</u>	

3. NAME OF DECEASED (Type or print) First <u>OLIVE</u> Middle <u>GERTRUDE</u> Last <u>HAHN</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>27</u> Year <u>1965</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>SEPT 5, 1883</u>	9. AGE (last birthday) <u>82.</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>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	11. BIRTHPLACE (City and state or country) <u>MARKLAND MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ANDREW BLAYLOCK</u>		13b. MOTHER'S MAIDEN NAME <u>WINNIE RICHARDS</u>		14. NAME OF HUSBAND OR WIFE <u>ALBERT A. HAHN - dec'd.</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. <u>UNKNOWN.</u>		17. INFORMANT Address <u>LELAND HAHN - DESLOGE - MO.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Multiple pulmonary infarcts plus Mesenteric thrombosis.</u>			<u>3 days</u>
DUE TO (b) <u>Arteriosclerotic heart disease, generalized arteriosclerosis</u>			<u>3 days</u>
DUE TO (c) _____			<u>unknown</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 <u>1957</u> to <u>Dec. 27, 1965</u> and last saw her alive on <u>Dec. 27, 1965</u> Death occurred at <u>10:23 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <u>J. H. Foster M.D.</u>		22b. ADDRESS <u>Desloge, Missouri</u>	22c. DATE SIGNED <u>12/30/65</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-30-65</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HILLVIEW MEMO GARDENS</u>	23d. LOCATION (City, town, or county) (State) <u>FARMINGTON - MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>CALDWELL SONS - FLAT RIVER, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 30, 1965</u>	26. REGISTRAR'S SIGNATURE <u>Eather R. Rudloff</u>

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1. 0941

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

JAN 12 1968

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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 David P. Caldwell

Licensed Embalmer No. 5184

P. O. Address Flat River, Mo.

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.