

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28627

Registration District No. 352

Primary Registration District No. 5493

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Henry  
(b) City or town Montrose (Rural)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Separatory Wash  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Georgetown  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME ANTON HAKE 200

8. (b) If veteran, name war u 8. (c) Social Security No. u

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Theresa Hake 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased May 11 1865  
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Montrose mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Anton Hake

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Theresa Sleitz

16. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Hake

(b) Address Montrose

17. (a) Burial (b) Date thereof Aug 6 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Montrose

18. (a) Signature of funeral director Lee & Welling

(b) Address Montrose

19. (a) 8-6-40 (b) W.E. Baggerl  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3  
year 1940 hour \_\_\_\_\_ minute 5 P.M.

21. I hereby certify that I attended the deceased from July 31  
19 40 to Aug 3 19 40  
that I last saw him alive on July 2 19 40  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Chronic myocarditis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

317 (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature R.L. Hansen (M. D. or other) MD  
Address Appleton City Date signed 8-5-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1232

Date Filed 9-3-40

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 M. E.  
on the 3d day of aug 1940, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision

Signed \_\_\_\_\_

Licensed Embalmer No. 1099

P. O. Address Appleton City 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 this body is not embalmed, above space should be left blank.