

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 13 1945  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 5

Registration District No. 174 Primary Registration District No. 5644

1. PLACE OF DEATH:  
(a) County Lafayette  
(b) City or town Washington  
(c) Name of hospital or institution: 2 mi. E.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
(Specify whether  
In this community Yes  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Lafayette  
(c) City or town Washington  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2 mi. E.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HARMON WAHL  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 20  
year 1944 hour 1 minute 25 AM.  
21. I hereby certify that I attended the deceased from Dec 15 1944 to Dec 20 1944  
that I last saw him alive on 12/20 1944  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Ola Haupt 6. (c) Age of husband or wife if alive 65 years  
7. Birth date of deceased Nov 3 1871  
(Month) (Day) (Year)

Immediate cause of death Ulcered cardiac & renal failure  
Due to Chronic Nephritic Excystosis  
Duration \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 73 Months 1 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Major findings: Of operations 31  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Dover MO  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer  
11. Industry or business \_\_\_\_\_

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?  
While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Washington MO Date signed 12/21/44

12. Name Harmon Wahl  
13. Birthplace not known  
(City, town, or county) (State or foreign country)  
14. Maiden name Sophia Haines  
15. Birthplace Bermann  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Ola Wahl  
(b) Address Washington, MO  
17. (a) Burial (b) Date thereof 12-21-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Dover, MO  
18. (a) Signature of funeral director [Signature]  
(b) Address Washington, MO  
19. (a) Feb-8-45 (b) Mrs. Fred Schwalb  
(Date received local registrar) (Registrar's signature)

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

400

Payne

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

2-12-42

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

Registered Apprentice No.

working under my personal supervision.

Signed

*Geo. McKean*

Licensed Embalmer No. 2983

P. O. Address *Livingston 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, fact should be so stated above.