

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-047163**

**FILED VS DEC 27 1960**

297

Registration District No. 6022 Registrar's No. 156

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Ray</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Twp</b>		Length of stay in 1b <b>3 days</b>		c. CITY OR TOWN <b>Napoleon</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>13 Highway</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>KATHRYN</b> Last <b>HAUCK</b>				4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>1960</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2/5/1871</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Nichols Ochs</b>			13b. MOTHER'S MAIDEN NAME <b>Ida (No record)</b>			14. NAME OF HUSBAND OR WIFE <b>Rev. Jacob Hauck</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Hauck Liberty, Missouri</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>gastrointestinal Hemorrhage</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								DUE TO (b) <b>Cause unknown</b>	
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			
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>9-18-51</b> to <b>12-14-60</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>12-14-60</b>				Death occurred at <b>9:30 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Walter Emburster D.O.</i>				22b. ADDRESS <b>Wellington, Mo.</b>		22c. DATE SIGNED <b>12-16-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/17/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls E. &amp; R.</b>		23d. LOCATION (City, town, or county) <b>Napoleon, Missouri</b>		(State)			
24. FUNERAL DIRECTOR <b>J. S. Sheppard Wellington, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>12-23-1960</b>		26. REGISTRAR'S SIGNATURE <i>Maluel Jackson</i>			

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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*J. Blair Shappard*

Licensed Embalmer No. 4179

P. O. Address Wilmington, N.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.