

S. No. 2  
OM-5-43  
Rev. 5-17-39  
I X36871

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED APR 23 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12390**  
Registrar's No. **32**

Registration District No. **11** Primary Registration District No. **4024**

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

1. PLACE OF DEATH:  
(a) County **Barry**  
(b) City or town **Cassville**  
(c) Name of hospital or institution: **Barry County Hospital**  
(d) Length of stay: In hospital or institution **1 day**  
In this community **most of life**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Barry**  
(c) City or town **Rural**  
(d) Street No. **Rt. 2, Seligman**  
(e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **Delia E. Hake**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **March** day **31st.**  
year **1947** hour **10** minute **45 P.M.**  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

4. Sex **F.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **George Andrew Hake** 6. (c) Age of husband or wife if alive **71** years  
7. Birth date of deceased **unknown 1878**  
(Month) (Day) (Year)

Immediate cause of death **Bilateral lobes pneumonia**  
Duration \_\_\_\_\_

8. AGE: Years **69** Months **unknown** Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) **108**

9. Birthplace **Cubbage Ky.**  
(City, town, or county) (State or foreign country)

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

10. Usual occupation **Housewife**  
11. Industry or business \_\_\_\_\_  
12. Name **Cowan**  
13. Birthplace **unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **unknown**  
15. Birthplace **unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **George E. Hake**  
(b) Address **Rt. 2, Seligman, Mo.**  
17. (a) **Burial** (b) Date thereof **4/3/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Roller Cemetery**

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? \_\_\_\_\_

18. (a) Signature of funeral director **Koon Funeral Home**  
(b) Address **Cassville, Mo.**  
19. (a) **Apr 7 - 1947** (b) **Grace William**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury **0**  
23. Signature **McCain** (M. D. or other) \_\_\_\_\_  
Address **Cassville, Mo.** Date signed **Apr 4**

RECEIVED

District Health Officer No. 6,

District File Number 447-449

Date Filed APR 22 1947

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 J. C. Canada.....

Licensed Embalmer No. 4196.....

P. O. Address Cassville, 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.