

S. No. 2
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5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10422**
Registrar's No. **102**

Registration District No. **316**

Primary Registration District No. **3059**

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

1. PLACE OF DEATH:
(a) County **St. Francis**
(b) City or town **Bonne Terre**
(c) Name of hospital or institution **Bonne Terre Hospital**
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **years** _____ (Specify whether _____)

3. (a) PRINT FULL NAME **James M. Hahn**
(b) If veteran name war _____ (c) Social Security No. _____

4. Sex **m** 5. Color or race **w**
6. (a) Single, widowed, married, divorced **widowed**
(b) Name of husband or wife **Jarvis Hahn (Second wife)**
6. (c) Age of husband or wife if _____
7. Birth date of deceased **March 14 1870** (Month) (Day) (Year)

8. AGE: Years **77** Months **10** Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **Bollinger Co mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

MOTHER FATHER { 12. Name **Henry Hahn**
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name **Katherine Johnson**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Florence Bollinger**
(b) Address **Flat River mo**

17. (a) **Burial** (b) Date thereof **3-27-47** (Month) (Day) (Year)
(c) Place: burial or cremation **Baldwell Bur**

18. (a) Signature of funeral director **Esther Rudloff**
(b) Address **Flat River mo**

19. (a) **3-31-47** (Date received local registrar) (b) **Esther Rudloff** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Francis**
(c) City or town **Flat River mo**
(d) Street No. _____ (If rural, give location) **2**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **24th** day **March**
year **1947** hour **4** minute **00** M.
21. I hereby certify that I attended the deceased from **March 1**
1947, to **March 24** 1947
that I last saw him alive on **March 24** 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerosis**
heart disease & disorganized
apex base
Duration _____

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: **A.D.**
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 **0**

23. Signature **J. L. Foster** (M. D. or other) _____
Address **Desloy mo** Date signed **3-28-47**

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APR 21 1947

RECEIVED

District Health Officer No. 4
District File Number 447-500
Date Filed 4-8-47

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 W.A. Baldwin

Licensed Embalmer No. 3317

P. O. Address Flat River on

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.