

58  
JUL 26 1929  
N. H.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

22396

1. PLACE OF DEATH

County Monteclair  
Township Walden  
City..... (No.....)

Registration District No. 571  
Primary Registration District No. 5769

File No.....  
Registered No. 34  
St. .... Ward)

2. FULL NAME

Martha Ann Hauer

(a) Residence. No..... St..... Ward.....  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) DEC 26 - 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
72 5 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Monteclair Co  
(STATE OR COUNTRY)

10. NAME OF FATHER Harry Hauer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Caroline Murrell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn  
(STATE OR COUNTRY)

14. INFORMANT Bert Hauer  
(Address) California Mo

15. Date June 6, 1929 James W. Raab  
REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 5 1929

17.

I HEREBY CERTIFY, That I attended deceased from.....

....., 19..... to....., 19.....  
that I last saw h..... alive on June 5 p, 1929, and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Hepatitis  
Gastro Enteritis  
131

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?

WHEN TEST CONFIRMED DIAGNOSIS?

(Signed) S. M. May, M. D.

, 19 (Address) California Mo

\*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Old Salem

6/7 1929

20. UNDERTAKER

ADDRESS

William Fred Meyer California

