

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. **314**

State of Oklahoma **26874** Registrar's No. **104**

1. PLACE OF DEATH: **McClain 44-54-7**
(a) County
(b) City or town **Purcell Okla**
(c) Name of hospital or institution:
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether

In this community _____
years, months or days)

3(a) FULL NAME **Samuel Kendrick Hauchope**

3(b) If veteran, _____ 3(c) Social Security No. **447-22-3647**

4. Sex **male** 5. Color or race **white** 6(a) Single, widowed, married, divorced **married**

6(b) Name of husband or wife **Ms. Olga K. Hauchope** 6(c) Age of husband or wife, if alive _____ years.

7. Birth date of deceased **April 28, 1871**
(Month) (Day) (Year)

8. AGE:			
Years	Months	Days	If less than one day
74	5	2	hr. min.

9. Birthplace **Virginia**
(City, town, or country) (State or foreign country)

10. Usual occupation **ooo**

11. Industry or business _____

12. Name **Joseph W. Hauchope**

13. Birthplace **Delington Virginia**
(City, town, or country) (State or foreign country)

14. Maiden name **Kate Kendrick**

15. Birthplace **Hamburg Virginia**
(City, town, or country) (State or foreign country)

16. (a) Informant's own signature **Mr. S. K. Hauchope**

(b) Address **Shawnee Okla.**

17. (a) **cremation** (b) Date thereof **Sept 20, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place; burial or cremation **Shawnee**

Was body embalmed? **Yes**
Signature of embalmer **Gayle H. Juncal**

18. (a) Signature of funeral director **Wm M. Gattum**

(b) Address **Purcell Okla.**

19. (a) **Sept 20 45** (b) **Clarence D. Jones**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **62569-7**
(a) State **Oklay** (b) County **Pottawatomie**
(c) City or town **Shawnee**
(If outside city or town limits, write RURAL)
(d) Street No. **502 N. Chapman**
(If rural give location) Yes or No

(e) Citizen of foreign country? _____
If yes, name country _____

MEDICAL CERTIFICATION

20. Date of death: Month **Sept** day **20**
year **1945** hour **1** minute **a.m.**

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____

that I last saw him alive on **Sept 20**, 19**45**;

and that death occurred on the date and hour stated above. Duration _____

Immediate cause of death **coronary thrombosis**

Due to **arteriosclerosis**

Due to **HTA**

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

Major findings: _____
Of operations _____

Of autopsy **none**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **no**

(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? **no**

(e) Means of injury _____
While at work? _____

23. Signature **W. C. Anderson** M.D. or other **W. C. Anderson**

Address **Purcell, Okla** Date signed **9/21/45**

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

VOID IF ALTERED OR ERASED

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