WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—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

PLACE OF DEATH

County: Davis

Township or Village or City: Jamesport (NO. ____, ____ St.; ____ Ward)

Registration District No. 252 — File No. 38411

Primary Registration District No. 4152 — Registered No. 21

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Alexander Haas

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widower

DATE OF BIRTH: Oct 20 - 1836 (Month) (Day) (Year)

AGE: 78 yrs. 2 mos. 4 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

BIRTHPLACE (City or town, State or foreign country): Ingenheim Germany

PARENTS
NAME OF FATHER: Do not Know
BIRTHPLACE OF FATHER (City or town, State or foreign country): " "
MAIDEN NAME OF MOTHER: " "
BIRTHPLACE OF MOTHER (City or town, State or foreign country): " "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Isaac Haas

(ADDRESS): Stanberry Mo

Filed Dec 30, 1914. C. L. McFinley, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

DATE OF DEATH: Dec 24 - 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 21, 1914, to Dec 24, 1914, that I last saw h~~im~~ alive on Dec 24, 1914, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ____ yrs. ____ mos. 1 ds.

Contributory (SECONDARY): Rheumatism

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R. V. Thompson M. D.

Dec 27, 1914 (Address) Jamesport, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: St Joseph - Mo.

DATE OF BURIAL: Dec 27 1914

UNDERTAKER: J. O. Brown

ADDRESS: Jamesport Mo

PLACE OF DEATH

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

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ...St.:.....Ward) [If death occurred hospital or instit give its NAME i of street and numb

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *1*
(Month) (Day) (Y

I HEREBY CERTIFY, that I attended deceased

....., 191...., to....., 19

that I last saw h.....alive on....., 19

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIEN RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS