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

Do not use this space.

29029

File No. 8613

Registered No.

1. PLACE OF DEATH

County

Registration District No. 791

Township

Primary Registration District No. 1003

City St. Louis Mo (No. Barnes Hospital St. Ward)

2. FULL NAME Leonard Haas

(a) Residence. No. 4666 Oldenberg St., 2 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: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 25-1910.

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
17	3	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis Co. Mo.

PARENTS

10. NAME OF FATHER: John Haas

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

12. MAIDEN NAME OF MOTHER: Katie Giesler

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

14. INFORMANT: Katie Haas
(Address) 4666 Oldenberg ave.

15. FILED SEP 27 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 25 - 1927.

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1927, to Sept 25, 1927 that I last saw h. 1 m alive on Sept 25, 1927 and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Duodenal Ulcer

11103

129 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Perforation Ulcer

Dodenum Peritonitis (duration) — yrs. — mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? ✓

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Ambrose Youngman, M. D.

9/26, 1927 (Address) Sappington 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: S. S. Peter + Paul

DATE OF BURIAL: Sept. 28 1927

20. UNDERTAKER: Ziegenheim Bros. 2623

ADDRESS: Cherokee

THIS IS A PERMANENT RECORD

Sappington

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.