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

Do not use this space.

35141

**1. PLACE OF DEATH**

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. 4241a, Red Bud St. ..... Ward)

File No. .....

Registered No. 10314

**2. FULL NAME** August Haase

(a) Residence. No. ..... St., 10 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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 29 - 1861

7. AGE: Years 66 | Months 6 | Days 16 | If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Chairmaker
(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): Germany

PARENTS

10. NAME OF FATHER: unknown

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

12. MAIDEN NAME OF MOTHER: unknown

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

14. INFORMANT: Mrs. Wm Ellis
(Address) 4241a Red Bud Av

15. FILED NOV 17 1927 Max C Starkoff REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 15 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 3:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency

92A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): W. M. A.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

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

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) R. S. Vitt, M. D

11/19, 1927 (Address) Coroner CC

*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: Zion Cemetery

DATE OF BURIAL: 11/18 1927

20. UNDERTAKER: Wm M. Schumacher

ADDRESS: 1844 N Jefferson

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.

[illegible] WITH UNFADING INKMITHIS IS A PERMANENT RECORD