

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City St. Louis (No.)

Registration District No. 791
Primary Registration District No. 1003

File No. 38167
10795
Registered No.
St. Ward)

2. FULL NAME

Cornelia H. Hassing
(a) Residence No. 3838 Botanical of 17 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 John H. Hassing

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 12 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
79 2 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
(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

10. NAME OF FATHER Joseph H. Polase

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

12. MAIDEN NAME OF MOTHER Not known

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

14. INFORMANT R. Henry Polase
(Address) 2938 Botanical Ave

15. FILED -2 1927 Mar 6 Starkoff
1927 REGISTER

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 2nd 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 7 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

CONTRIBUTORY (SECONDARY)

W.M.A.
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

9 WAS THERE AN AUTOPSY.....

10 WHAT TEST CONFIRMED DIAGNOSIS?

171 St. Peter (Signed) W. F. Paschedag, M.D.

11, 12 Address 2938 Botanical Ave

*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

St. Peter DATE OF BURIAL Dec. 4th 1927

20. UNDERTAKER

W. F. Paschedag ADDRESS 2825 No Grand

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.

