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

Do not use this space.

19316

File No.

Registered No.

1. PLACE OF DEATH
County Worth Registration District No.
Township Eletchall Primary Registration District No.
City Grant City (No. St. Ward)

2. FULL NAME Sarah M Hass

(a) Residence, No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

JUN 27 1934

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 16, 1851

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	82	11	19	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 1933
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Holmes Co. Ohio

FATHER
13. NAME Allen Hass
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

MOTHER
15. MAIDEN NAME Nancy J. Jobe
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

17. INFORMANT (ADDRESS) Wayne Hass Grant City, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Grant City Cem DATE 5/7, 1934

19. UNDERTAKER (ADDRESS) Arch C. Dunlee Grant City Mo.

20. FILED June 9, 1934 Fred Mull M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-5-34

22. I HEREBY CERTIFY, That I attended deceased from April 1, 1934, to 5-5-, 1934
I last saw her alive on 5-5-, 1934. Death is said to have occurred on the date stated above, at 4:20 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia (Left Lung)	3-2
5-2	

Other contributory causes of importance:

Name of operation ..... Date of
What test confirmed diagnosis? X Ray Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) S. J. Rose, M. D.
(Address) Grant City Mo.

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.