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.

REC'D MAY 10 1939

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

891
1003

12914
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. .....
(b) Township ..... Primary Registration District No. ..... Registered No. 3256
(c) City St. Louis (d) Street No. City Hospital No.1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

D. 19014

2. PRINT FULL NAME 600 Ethel Haar
(a) Residence, No. 208 South 6th St. 25
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
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 Marc Arthur Haar

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 2, 1914

7. AGE YEARS 25 MONTHS 1 DAYS 3 If LESS than 1 day, ... hrs. or ..... min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wittenburg Missouri 0

FATHER
13. NAME Martin Thompson 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wittenburg Missouri 0

MOTHER
15. MAIDEN NAME Minnie Strickland
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Seventy-Six Missouri

17. INFORMANT (ADDRESS) Hosp. Info M.Kent

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Olive DATE April 7, 1939

19. FUNERAL DIRECTOR (NAME) John J Kassly
(ADDRESS) 1101 N 9th St. E. St. Louis, Ill.

20. FILED ..... 19 ..... J. B. Bulick Local Registrar.
APR 6 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/5/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 3/30/39, 19..., to 4/5/39, 19...
I last saw her alive on 4/5/39, 19... Death is said to have occurred on the date stated above, at 11.15 ma
The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis

Date of onset

Other contributory causes of importance: JB

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....
If so, specify .....
(Signed) Jos L Lucido, M. D.
(Address) City Hospital No.1

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, Paul A. Keith, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Paul A. Keith

Licensed Embalmer No. 3612

P. O. Address 2317 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.