

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 230

Primary Registration District No. 4140

Registrar's No. 60

1. PLACE OF DEATH
(a) County Crawford
(b) City or town Emble mo
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 (Specify whether years, months or days) (Specify whether years, months or days)

3. (a) PRINT FULL NAME Edward Haas
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mertle Haas 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 9 - 1868 (Month) (Day) (Year)

8. AGE: Years 71 Months _____ Days 21 If less than one day hr. _____ min.

9. Birthplace Franklin Co MO (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

MOTHER FATHER
11. Industry or business _____
12. Name Jordan L. Haas
13. Birthplace Pa (City, town, or county) (State or foreign country)
14. Maiden name Mary Kathin Sarah
15. Birthplace Pa (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mertle Haas
(b) Address Emble mo

17. (a) _____ (b) Date thereof 9-24-1939 (Month) (Day) (Year)
(c) Place: burial or cremation Caton Cemetery

18. (a) Signature of funeral director L. James
(b) Address Shelville MO

19. (a) Sept 24/39 (b) G. G. A. Herzog (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 21 year 1939 hour 9 minutes _____ M.
21. I hereby certify that I attended the deceased from Sept 11, 1939, to Sept 18, 1939; that I last saw him alive on Sept 15, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 206 (Specify type of place) (e) Means of injury _____

23. Signature A. N. Harne (M. D. or other) _____
Address Steppville, Mo. Date signed 9-23-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.