

JAN 17 1941

Registration District No. 398

Primary Registration District No. 3019

Registrar's No. 298

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State #4 - Independence, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Independence (RURAL)
(If outside city or town limits, write "RURAL")
(d) Street No. State #4
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

8. (a) PRINT FULL NAME KATHERINE JOANNE HAAS

8. (b) If veteran, name war none 8. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 14 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>2</u>	<u>15</u>	hr. _____ min.

9: Birthplace Kansas City, MO
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

MOTHER FATHER { 12. Name E. Hale Haas

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Phyllis Rydger

15. Birthplace Kansas City, MO
(City, town, or county) (State or foreign country)

16. (a) Informant E. Hale Haas

(b) Address Independence, Mo.

17. (a) Burial (b) Date thereof 11/17/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grand Chapel

18. (a) Signature of funeral director Boyd Carson

(b) Address Independence, Mo.

19. (a) Nov 2 40 (b) F. L. Cook
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29
year 1940 hour 5 minute 20 P.M.

21. I hereby certify that I attended the deceased from Sept. 15, 40
_____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hemorrhage.
Hydrocephalus.

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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? 360

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. M. Cook (M. D. or other) _____

Address 1624 Pines Blv Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1592

Dr. Seiberg
1624 Independence St
Rt 2

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..... *Robert E. Mills*.....
Licensed Embalmer No. *4124*.....
P. O. Address..... *Independence, Mo.*.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42774

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 398

Primary Registration District No. 3019

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. Jackson

(b) City or town. Independence
(If outside city or town limits, write "RURAL" and name of township)

(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 _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Katherine Joanne Haas

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced child

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years Months Days If less than one day

2 10

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 29 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19 _____ to _____, 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Hydrocephalus

Due to _____

Due to Congenital 157W

Other conditions _____ (Include pregnancy within 3 months of death)

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? _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address 732 4th St. Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

