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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29981

State File No.

Registrar's No.

Registration District No. 1818

Primary Registration District No. 1000

8228

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 3 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5671 Waterman Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Samuel Haas

3. (b) If veteran, name war NONE 3. (c) Social Security No. 492-01-2963

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Martha Haas 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased May 18, 1872
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Man'f of Womens hats

11. Industry or business _____

MOTHER FATHER { 12. Name Elias Haas
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Theresa Levy
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address 5671 Waterman Ave

17. (a) Burial (b) Date thereof 9/16/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Mayer
(b) Address 4356 Lindell Blvd

19. (a) SEP 15 1943 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14
year 1943 hour 8 minute A. M.

21. I hereby certify that I attended the deceased from Sept 7, 1943 to Sept 14, 1943, that I last saw him alive on Sept 14, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Failure
Arteriosclerosis General
Due to Chronic Myocarditis
Diabetes Mellitus
Duration Two months
Several years

Other conditions (Include pregnancy within 3 months of death) 61

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____

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) (e) Means of injury _____
23. Signature Heriman M. Meyer (M. D. or other) mo.
Address 508 N. Grand Date signed 9/18/43

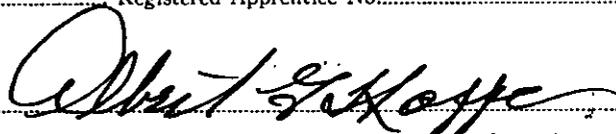
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1974

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..... 2971.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9228

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(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 _____
years, months or days)

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

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

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

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

10. Usual occupation _____

11. Industry or business _____

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 Martha Haas

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-15-43 (b) J.F. Bredeck
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 14
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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 _____
Duration _____

Due to _____
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)
(e) Means of injury _____

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

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

29981