

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30135**
Registrar's No. **3672**

FILED SEP 26 1944

Registration District No. **149**

Primary Registration District No. **1002**

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

49
23
7

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **11 days**
(Specify whether)

In this community **17 years**
years, months or days

3. (a) PRINT FULL NAME **Augusta W. Haase**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **NONE**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **LOWIS H. Haase**

6. (c) Age of husband or wife if alive **74** years

7. Birth date of deceased **August 8 1876**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
68	1	1	hr. min.

9. Birthplace **New Haven Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER { 12. Name **Henry Sheer**

13. Birthplace **Prusen Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Louise UNKNOWN**

15. Birthplace **Prusen Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Victor Haase**

(b) Address **3412 Agness**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **9 11-1944**
(Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem**

18. (a) Signature of funeral director **George Larson**

(b) Address **Independence Mo**

19. (a) **9-11-44** (Date received local registrar)

(b) **J. E. Brown** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Independence**
(If outside city or town limits, write "RURAL")

(d) Street No. **1821 Appleton**
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) **No**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **9**
year **1944** hour **2** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **8-30**, 19**44** to **9-9**, 19**44**
that I last saw him alive on **9-9**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death:
**Thrombophlebitis;
Toxic Hepatitis;**

Due to **intestinal obstruction**

Due to **Carcinoma of ascending colon**

Other conditions (Include pregnancy within 3 months of death) **462**

Major findings: **Carcinoma of ascending colon**

Of operations

Of autopsy

Duration

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 **H. B. Langbeef** (M. D. or other)

Address **H. C. Mo** Date signed

Prof. George W. Carson
Mar. 1. 1915

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..... *George W. Carson*

Licensed Embalmer No. *2249*

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, fact should be so stated above.