

S. No. 2
8-43
3-17-39
1 X 97 823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35932
8899

FILED NOV 30 1944 818

1003

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ENROUTE TO CITY HOSPITAL NO 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
Life 3 (Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town..... ST. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2406 S 12th St
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME LORENZ J HAESSEL

3. (b) If veteran, name war..... 3. (c) Social Security No. 498-0381107

20. DATE OF DEATH: Month Nov day 10
year 1944 hour 1 00 P.M. minute 15 P.

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.....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
Mabel Haessel June 17 1878
(Month) (Day) (Year)

Due to: Coronary Sclerosis
Arteriosclerosis
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
66 5 2 hr. min.

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name Adam Haessel
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Kathryne Elormis
(b) Address 2406 S 12th St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24/44
(Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Thoodetes & Son
(b) Address 2906 Gravois Ave

19. (a) NOV 21 1944 (Date received local registrar) (b) J. F. Budek (Registrar's signature)

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?
(Specify type of place)

While at work? Yes (6) Means of injury.....
23. Signature James J. Fitzhugh (M. D. or other)
Address 1309 Cedar Date signed 11-20-44

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

DEC 4 1928

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 David Van Fossen
Licensed Embalmer No. 4242
P. O. Address 2906 Gram

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 265

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9899

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

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St. Louis
(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.....
years, months or days)

3. (c) PRINT FULL NAME Lorenz J. Haessel

3. (b) If veteran, name war..... 3. (c) Social Security No.

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

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

7. Birth date of deceased June 17
(Month) (Day) (Year)

8. AGE: Years 66 Months 5 Days 5 If less than one day, hr. min.

9. Birthplace Mo.
(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.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) DEC 2 1944 (b) J. F. Bredek
(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 Nov year 1944 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from 1916 to 1944 that I last saw him alive on 1944 and that death occurred on the date and hour stated above.

Immediate cause of death.....

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?
(Specify type of place)

While at work?..... (c) Means of injury.....

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

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

35932