

FILED MAR 20 1945

Registration District No. 258

Primary Registration District No. 390 5882

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Osage
 (b) City or town Folk no incision
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: John
 (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 Frank H. Haselhorst

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

4. Sex male 5. Color or race w
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Mary Haselhorst
 6. (c) Age of husband or wife if alive 58 years
 7. Birth date of deceased April 16 1874
 (Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 0
 If less than one day _____ hr. _____ min.

9. Birthplace St. Liberty Illinois
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmy

11. Industry or business _____

12. Name Anton Haselhorst 11

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

14. Maiden name Mary Sampson 4

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

16. (a) Informant Harman Haselhorst

(b) Address Folk mo

17. (a) Burial (b) Date thereof Feb 20 1945
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Anthony cemetery

18. (a) Signature of funeral director H. H. Strop
 (b) Address Meta mo

19. (a) 2-18-45 (b) Rose Rowan
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Osage 76
 (c) City or town _____ (If outside city or town limits, write "RURAL") 0
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb- day 17
 year 1945 hour 9 minute 6 M.

21. I hereby certify that I attended the deceased from March 1st, 1945 to Feb-17, 1945;
 that I last saw him alive on Feb-10, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration _____

Due to Chronic Endocarditis

Due to 92d

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

Major findings: _____ Of operations _____

Of autopsy no

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 Hayden S. Beckwith (M. D. or other)
 Address Meta Mo Date signed Feb 19 45

574

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 3-19-45

JUN 20 1958

MAR 20 1945

MAR 20 1945

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 H. H. Strop

Licensed Embalmer No. 2924

P. O. Address Meta 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.

Registration District No. 258 Primary Registration District No. 5882

1. PLACE OF DEATH:
(a) County Osage
(b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township) surge
(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 Frank H. Haselhorst
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 M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 16 (Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days _____ If less than one day _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country) Ill

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)

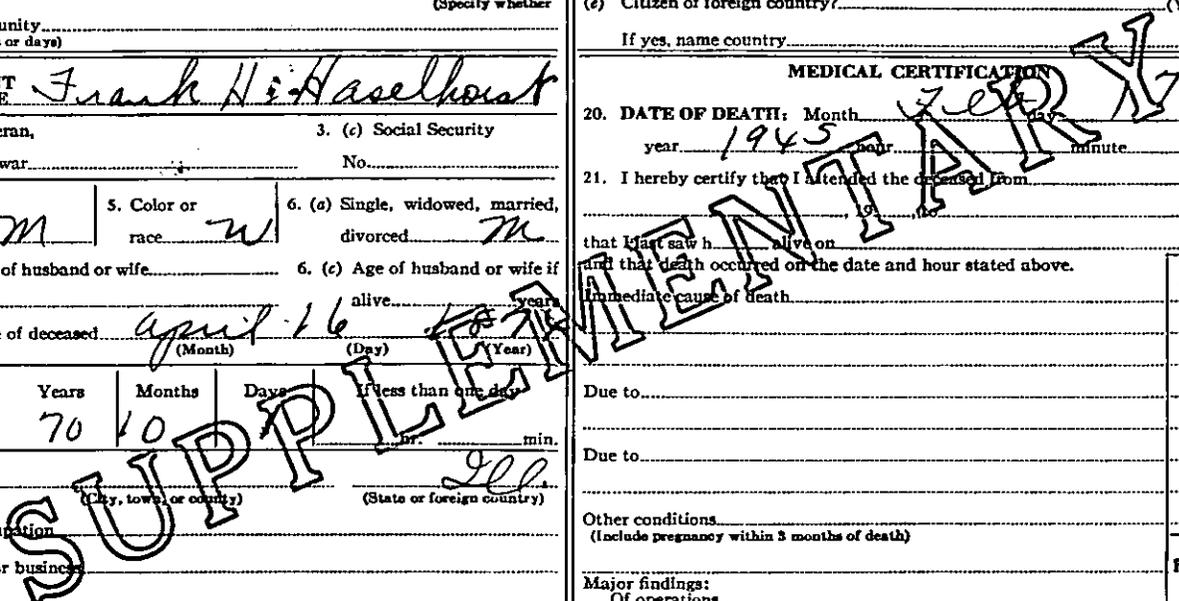
16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Osage
(c) City or town Rural (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 Feb year 1945 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 _____

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 _____



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

MOTHER FATHER

10329