

S. No. 2
M-5-43
7-5-17-39
P I 3867

LED SEP 1 1945 318

1003

Registrar's No. **2461**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
1905a Destrehan St. /
(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)

In this community 74 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1905a Destrehan St. 9
(If rural, give location)

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

3. (a) PRINT FULL NAME Joseph Hass

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

4. Sex M. Color or race W.

6. (a) Single, widowed, married, divorced W. /

6. (b) Name of husband or wife Pauline Hass

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

7. Birth date of deceased March 8th., 1850
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>95</u>	<u>5</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation Farmer, Retired

11. Industry or business _____

MOTHER FATHER

12. Name Lawrence Hass

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Pearl Barthel

(b) Address 1905a Destrehan St.

17. (a) Burial (b) Date thereof 8-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) AUG 22 1945 J. J. Budek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 27th., year 1945 hour 11 minute 8 M.

21. I hereby certify that I attended the deceased from June 19 1945 to Aug 15 1945 that I last saw him alive on Aug 15 1945 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Prostatic Cancer

Due to Chronic Myocarditis

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 J. J. Budek (M. D. or other) _____
Address 11901 Madison St. Date signed 8-28-45

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

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address. 3840 Lindsell Blvd

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.