

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10138

State File No. _____
Registrar's No. 2115

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. _____		Registrar's No. 2115					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____									
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		17 9							
d. FULL NAME OF HOSPITAL OR INSTITUTION Faith Hospital				d. STREET ADDRESS (If rural, give location) 4817 Leduc									
3. NAME OF DECEASED a. (First) Belle			b. (Middle) _____			c. (Last) Haskett			4. DATE OF DEATH (Month) (Day) (Year) March 16, 1949				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 8/24/1874		9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) St. Peters, Mo.		12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME Edwin Thorpe			13b. MOTHER'S MAIDEN NAME Catherine Unknown			14. NAME OF HUSBAND OR WIFE Andrew J. Haskett							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____			16. SOCIAL SECURITY NO. _____			17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frances Zorensky 4402 McPherson							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis + Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility 19. DATE OF OPERATION 6/11									
19a. DATE OF OPERATION 6/11				19b. MAJOR FINDINGS OF OPERATION None						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____									
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____									
22. I hereby certify that I attended the deceased from 3-5, 1949 to 3-6, 1949 that I last saw the deceased alive on 3-6, 1949, and that death occurred at 7:00 a.m., from the causes and on the date stated above.													
23a. SIGNATURE J. P. Berman (Degree or title) M.D.				23b. ADDRESS 1225 - No. Grand				23c. DATE SIGNED 3-7-49					
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/9/49		24c. NAME OF CEMETERY OR CREMATORY Mount Zion Cem		24d. LOCATION (City, town, or county) O'Fallon, Mo. (State) _____							
DATE REC'D BY LOCAL MAR 7 1949 REG.		REGISTRAR'S SIGNATURE J. B. Foster				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Funeral Dir. 2849N. Euclid							

Dr. J.P. Berman

1225 North Grand

Je 18 Ho Mon 1 to 3³⁰ pm

Murray

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed

Robert M Murray

Signed _____
Student Embalmer

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

State File No. 10134-69

Local Registrar's No. 2115

State of _____ }
County of _____ } ss.

AFFIDAVIT FOR CORRECTION OF A RECORD

On this 29th day of April, 1949, before me appears _____

James R. Walsh (Sullivan Undergoer) his oath, states that the original record of birth death for Palle Haskett (Dac'd), died born 3-6-49, 19____, in the State of Missouri, and which was filed at _____ on _____, 19____, should be corrected as follows:

Item No. 13B should read Catherine Trenley
Unknown

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant: *James R. Walsh* Sullivan *Sullivan* Fun. Director
Relationship.

2949 N. Euclid
Present Address.

Subscribed and sworn to before me this 29 day of April, 1949

My Commission expires 3-4-53 _____ Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

