

FILED JAN 14 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42536

State File No. \_\_\_\_\_

Registrar's No. 11227

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>11227</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Clinton</b>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis</b> )		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>Breese</b>		d. STREET ADDRESS (If rural, give location) <b>N.R.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Barnes Hospital</b>							
3. NAME OF DECEASED (Type or Print) a. (First) <b>Henry</b> b. (Middle) <b>J.</b> c. (Last) <b>Haar</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 28, 1949</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Nov. 5, 1918</b>	
9. AGE (In years last birthday) <b>31</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Lumberton, Miss.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>Fred Haar</b>		13b. MOTHER'S MAIDEN NAME <b>Wilhelmina Grawe</b>		14. NAME OF HUSBAND OR WIFE <b>Mildred Morrison</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>343-07-3495</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mildred Haar, Breese, Ill.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Gastric Hemorrhage from Ruptured Esophagus</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: <b>Varic Cirrhosis of the Liver</b> 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.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Breese, Ill.</b>			
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>4:55 A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE (Degree or title) <b>Gabriel E. Taylor, M.D.</b>				23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>12/29/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>12-28-49</b>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <b>Breese, Ill.</b>	
DATE REC'D BY LOCAL REG. <b>DEC 29 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Farster</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>			

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

*S*

**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.

Student .....  
Student Embalmer

Signed: *Robert M Murray*

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.