

FILED AUG 22 1955

STANDARD CERTIFICATE OF DEATH

25360
State File No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|-----------------------------|
| BIRTH NO. | | REG. DIST. NO. 42 | | PRIMARY REG. DIST. NO. 1000 | | Registrar's No. 860 | | |
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph | | c. LENGTH OF STAY (in this place) 27 yrs | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph | | d. STREET ADDRESS (If rural, give location) 2600 Indian Trail | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1515 N. 10th St. Elliott Nursing Home | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Louis | | | b. (Middle) A. | | c. (Last) HAAS | | 4. DATE OF DEATH (Month) (Day) (Year) August 8, 1955 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH June 18, 1868 | | 9. AGE (In years last birthday) 87 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Agriculture | | 11. BIRTHPLACE (City and State or Foreign Country) Peoria, Illinois. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME Fredinand Haas | | | 13b. MOTHER'S MAIDEN NAME Victoria Alig | | 14. NAME OF HUSBAND OR WIFE Mary Victoria Haas | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dr. Wm. A. Haas St. Joseph, Mo. | | | | | |
| 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) Acute Heart failure ANTECEDENT CAUSES Subcapital fracture Femoral neck DUE TO (b) Right DUE TO (c) Arteriosclerosis generalc Arteriosclerotic Heart disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 hrs. approx 30d ? ? | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION E9049 | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) St. Joseph, Mo. | | | | |
| 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 131 46 | | | | |
| 22. I hereby certify that I attended the deceased from 8-8-55 to 8-8-55 , that I last saw the deceased alive on 7-23, 1954 , and that death occurred at 4:50P m., from the causes and on the date stated above. | | | | | | | | |
| 23. SIGNATURE Wm B Koolind (Degree or title) 12 year for patient in absence of Dr. Hartigan | | | | 23b. ADDRESS 316 No 10th St. Joseph, Mo. | | 23c. DATE SIGNED 8-10-55 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE Aug. 11, 1955 | 24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri. | | | | |
| DATE REC'D BY LOCAL REG. Aug. 16, 1955 | REGISTRAR'S SIGNATURE Esther M. Allison | | | 25. FUNERAL DIRECTOR'S SIGNATURE Preischerhoff | | ADDRESS St. Joseph, Mo. | | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

** ****

Student Embalmer No. _____ **

working under my personal supervision.

Student ** ***
Student Embalmer

Signed Edward R. Harrington

Licensed Embalmer No. 3258 Mo.

P. O. Address St. Joseph, 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.