

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046622

FILED VS JAN 13 1961

160

559

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

NDED

1. PLACE OF DEATH a. COUNTY <b>JEFFERSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Louis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JOACHIM</b>		Length of stay in lb <b>—</b>		c. CITY OR TOWN <b>ST ANN</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Jeff Mem Hosp</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3503 St Sebastian</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Oliver Haase</b>				4. DATE OF DEATH <b>12-26-60</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/29/43</b>		
9. AGE (last birthday) <b>17</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>		11. BIRTHPLACE (City and state or country) <b>St Louis, Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>LOUIS HAASE</b>			13b. MOTHER'S MAIDEN NAME <b>MARGARET OHLENDORF</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>LOUIS HAASE</b> Address <b>3503 St Sebastian St Ann, Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Fractures</b>							INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>single car Accident.</b>				
20c. TIME OF INJURY <b>4:00 p.m.</b>		Month, Day, Year <b>12-26-60</b>						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway.</b>		20f. CITY, TOWN, OR LOCATION <b>Valle Twp.</b>		COUNTY <b>Jeff.</b> STATE <b>Mo.</b>		
21. I attended the deceased from <b>CORONER'S VIEW.</b> and last saw her <b>4:00 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at _____								
22a. SIGNATURE (Degree or title) <b>James C. Peltard M.D. Crown</b>				22b. ADDRESS <b>Fortia Mo.</b>		22c. DATE SIGNED <b>12-26-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/29/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope</b>		23d. LOCATION (City, town, or county) (State) <b>Lemay Mo</b>		
24. FUNERAL DIRECTOR <b>MAHN Funeral Home</b> ADDRESS <b>De Soto, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>12/29/60</b>		26. REGISTRAR'S SIGNATURE <b>John N. Stoll</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Ronald J. Mar*

Licensed Embalmer No. *497*

P. O. Address *De Soto,*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.