

FILED APR 6 1944
Registration District No. 9894

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7417 Washington /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 5 Mo
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 7417 Washington
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Gene Norman Haas
(b) If veteran, name war No
(c) Social Security No. None

4. Sex Male 5. Color or race Wh
6. (a) Single, widowed, married, divorced Single
(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Oct 26 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 4 20 hr. min.

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

10. Usual occupation home

11. Industry or business _____

MOTHER FATHER

12. Name Clifton L. Haas
13. Birthplace Harrington Kans
(City, town, or county) (State or foreign country)
14. Maiden name Marie Adamson
15. Birthplace Emporia Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Clifton L. Haas
(b) Address 7417 Washington
17. (a) Removal (b) Date thereof 3-18-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ottawa Kansas

18. (a) Signature of funeral director [Signature]
(b) Address 7406 Wornall Rd
19. (a) 3-17-44 (b) T. E. Brown (V 3)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 16
year 1944 hour 10 AM minute _____ M.
21. I hereby certify that I attended the deceased from March 14, 1944 to March 16, 1944
that I last saw him alive on March 15, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Acute BronchoPneumonia 7 da
Duration

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy 107
Underline the cause to which death should be charged statistically.

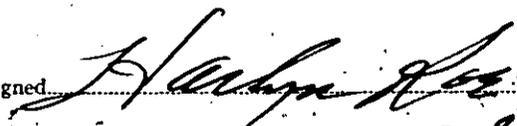
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. H. Fair (M. D. or other)
Address 404 1/2 W 75 Date signed 3/16/44

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



Licensed Embalmer No. 2810

P. O. Address 116

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.