

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28110
Registrar's No. 7668

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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 township) OR TOWN St. Louis Mo. c. LENGTH OF STAY (In this place) _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Pacific Hosp d. STREET ADDRESS (If rural, give location) 3116 Eads Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Mattie b. (Middle) Jane c. (Last) Haas
4. DATE OF DEATH (Month) (Day) (Year) Sept 4 1949

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 8. DATE OF BIRTH July 17 1880 9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months 1 Days 17 IF UNDER 24 HRS. Hours 17 Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) Mokane, Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jackson Ewing Harris 13b. MOTHER'S MAIDEN NAME Mary Margaret Saunders 14. NAME OF HUSBAND OR WIFE Albert Haas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Mrs. Robert Penning ADDRESS 3116 Eads Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation
ANTECEDENT CAUSES (b) Chronic Myocarditis
DUE TO (c) _____
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)
20. AUTOPSY? YES NO

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____

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) 93

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 4370

22. I hereby certify that I attended the deceased from Sept 2 1949, to Sept 4 1949, that I last saw the deceased alive on Sept 2 1949 and that death occurred 11:30 a.m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W.D. M.D. ADDRESS: 1703 So. Almond 23c. DATE SIGNED 9-5-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE Sept 5 1949 24c. NAME OF CEMETERY OR CREMATORY Riverview 24d. LOCATION (City, town, or county) (State) Jefferson City Mo.

DATE REC'D BY LOCAL REG. SEP 5 1949 REGISTRAR'S SIGNATURE J. B. Kasater 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thorpe J. Gordon

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

J. W. M. Denbley

Licensed Embalmer No.

3653

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.