

APR 23 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

12219

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

Registration District No. 760 B

Primary Registration District No. 6001

Registrar's No. 107

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town O'Fallon, Mo.  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) \_\_\_\_\_  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 40 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Charles  
(c) City or town O'Fallon, Mo.  
(If outside city or town limits, write "RURAL") \_\_\_\_\_  
(d) Street No. 0  
(If rural, give location) \_\_\_\_\_  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 28  
year 1940 hour 7 minute 30 P. M.  
21. I hereby certify that I attended the deceased from Jan 15 1938  
15, 1938, to Mar 28, 1940;  
that I last saw her Mar 25 alive on \_\_\_\_\_, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia  
Due to metastatic carcinoma  
Due to Cervix uteri  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 4 1/2

Duration

1938

PHYSICIAN

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature Nicholas Horuch (M. D. or \_\_\_\_\_)  
Address O'Fallon Mo Date signed 4-8-40

3. (a) PRINT FULL NAME S. R. M. REGIDIA 230  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 8 6 1879  
(Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Piute City, Mo. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Art Embroidery

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Martin Schlumert ;  
13. Birthplace Piute City, Mo. Mo. 0  
(City, town, or county) (State or foreign country)  
14. Maiden name Julia Hagedorn  
15. Birthplace Piute City, Mo. Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant J. M. Innocentia  
(b) Address O'Fallon, Mo.

17. (a) Burial (b) Date thereof April 1, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Quincy Blood Control Cem.

18. (a) Signature of funeral director H. C. Dalleney & Sons Co While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(b) Address 800 N. Second, St. Charles, Mo. (c) Means of injury \_\_\_\_\_

19. (a) April 3 1940 (b) E. O. Reithly 100  
(Date received local registrar) (Registrar's signature)

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

72

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MISSOURI DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
BUREAU OF VITAL RECORDS

**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.....

Joseph Landolt Registered Apprentice No. 243  
working under my personal supervision.

Signed John E. Dallmeyer  
Licensed Embalmer No. 2957  
P. O. Address St Charles 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, above space should be left blank.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12219

Registration District No. 760B

Primary Registration District No. 6001

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County St. Charles  
(b) City or town Dardenne T.P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
\_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Dr. Mary Virginia R. Schell  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 60 Months 7 Days 22 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Jan 30/41 (b) E. A. Keethley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 3 day 28  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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?  
\_\_\_\_\_  
(Specify type of place)  
While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature Nicholas Houch (M. D. or other) \_\_\_\_\_  
Address Talbot, Mo Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

1940

S-12219

100

Jan 20 1940