

Registration District No. **14-134757**

Primary Registration District No. **3036**

Registrar's No. **77**

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town St Charles
(c) Name of hospital or institution:
729 Jackson St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 63 years
In this community 63 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MRS. MARGARETHE STRUCKMANN
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 Married
6. (b) Name of husband or wife Herman Struckmann
6. (c) Age of husband or wife if alive 84 years
7. Birth date of deceased March 8th 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days 1
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____
12. Name Herman Struckmann
13. Birthplace Not known
(City, town, or county) (State or foreign country)
14. Maiden name Aura Lemme
15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Peter J. Struckmann
(b) Address _____

17. (a) Burial (b) Date thereof May 12, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lutheran Cemetery

18. (a) Signature of funeral director Hackmann - Dew
(b) Address 367 N 6th St - St Charles Mo

19. (a) 5/11/40 (b) Glenn S. Neesler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Charles
(c) City or town St Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 729 Jackson St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 63 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 9
year 1940 hour 5 minute 30 P. M.
21. I hereby certify that I attended the deceased from 1-29-38
to 5-9-40, 19____, to 5-9-40, 19____
that I last saw her alive on 5-9-40, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 6 days
Due to _____
Due to _____
Other conditions Chr. nephritis 2 yrs.
(Include pregnancy within 3 months of death)
PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings: _____
Of operations 121
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?
670
While at work? RA Andice (Specify type of place) (e) Means of injury
23. Signature RA Andice (M. D. or other) _____
Address 200 Gray M. Date signed 5/10/40

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X1931

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 *Arthur C. Baul*.....

Licensed Embalmer No. *3155*.....

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.