

Registration District No. 257

Primary Registration District No. 3036

Registrar's No. 139

1. PLACE OF DEATH:

(a) County ST. CHARLES
(b) City or town ST. CHARLES
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1718 NO 4th STREET
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community 2 YEARS (Specify whether years, months or days)

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. 1718 NO 4th STREET
(If rural, give location)
(e) If foreign born, how long in U. S. A. 61 years

3. (a) PRINT FULL NAME ELIZABETH KOBAN
(b) If veteran, name war L
(c) Social Security No. L

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 3
year 1940 hour 6 minute P. M.

4. Sex 7
5. Color or race W
6. (a) Single, widowed, married, divorced MARRIED
(b) Name of husband or wife FRANK R KOBAN
(c) Age of husband or wife if alive 64 years
7. Birth date of deceased JUNE 5 - 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 26, 1940, to Aug 3, 1940.
that I last saw her alive on Aug 3, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia
Duration July 26

8. AGE: Years 67 Months 1 Days 28
If less than one day hr. min.

Due to Hypertension
Due to Do not know

9. Birthplace GERMANY
(City, town, or county) (State or foreign country)
10. Usual occupation HOUSE WIFE

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business
12. Name CHRIS TOPHER LABILL
13. Birthplace GERMANY
14. Maiden name AMALIE WIERERE
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Frank R Koban
(b) Address 1718 N. 4th St
17. (a) BURIAL (b) Date thereof Aug. 6 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MEMORIAL PARK
18. (a) Signature of funeral director L. B. Tanner
(b) Address 6107 Natural Bridge Rd
19. (a) 8/3/40 (b) Clarence B. Messler
(Date received local registrar) (Registrar's signature)

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 Vicente A. Schmitter (M. D. or other) MD
Address St Charles, Mo. Date signed 8/5/40

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

Rev. 5-17-39
1 X1951
-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.

828

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 J. S. Sullivan
Licensed Embalmer No. 1125

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29493**
Registrar's No. **159**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **757**

Primary Registration District No. **3036**

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

ROWENA MOORE

St Charles, Mo.

1. PLACE OF DEATH:

(a) County. **St Charles**

(b) City or town. **St Charles**
(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 years, months or days)

In this community _____

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.

3. (a) PRINT FULL NAME **Elizabeth Koban**

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 **m**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67 1 28 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **aug** day **3** year **1946** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Somnolence**

Hypertension

Due to **cerebral hemorrhage**

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

Major findings: **f2k**

Of operations _____

Of autopsy _____

Duration _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Vincent A. Schuman** (M. D. or other) **MD**

Address **St Charles, Mo** Date signed **oct 26 1946**

SUPPLEMENTAL

