

Registration District No. **757**

Primary Registration District No. **3036**

Registrar's No. **199**

1. PLACE OF DEATH: **St. Charles**  
 (a) County **St. Charles**  
 (b) City or town **St. Charles**  
 (c) Name of hospital or institution: **721 Clark St**  
 (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 **2**

3. (a) PRINT FULL NAME **MRS KATHERINE PLACKEMEIER**  
 3. (b) If veteran, name war **V**  
 3. (c) Social Security No. **NONE**

4. Sex **Female** 5. Color of race **White**  
 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **John Henry Plackemeier**  
 6. (c) Age of husband or wife if alive **✓** years

7. Birth date of deceased: **August 28th 1854**  
 (Month) (Day) (Year)

8. AGE: Years **86** Months **✓** Days **22** 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 **6**

MOTHER FATHER  
 { 12. Name **John Mecke** **6**  
 13. Birthplace **Germany**  
 (City, town, or county) (State or foreign country)  
 { 14. Maiden name **Maria Eliza Bode**  
 15. Birthplace **Germany**  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. A. H. Lueding**  
 (b) Address **St. Charles Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 22, 1940**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Lutheran Cemetery**

18. (a) Signature of funeral director **Hackmann, Bode**  
 (b) Address **326 N 6th St - St. Charles, Mo**

19. (a) **11/20/40** (b) **Clarence G. Heister**  
 (Date received local registrar) (Registrar's signature) **(R.C.)**

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. **721 Clark St**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **20**  
 year **1940** hour **3** minute **A. M.**

21. I hereby certify that I attended the deceased from **Oct 27**, 19**40** to **Nov 20**, 19**40**,  
 that I last saw her alive on **Nov 19**, 19**40**,  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Broken Compensation**  
 Due to **Gen Arterio sclerosis** 3 day  
 10 yrs.  
 Due to **Chronic Nephritis** 10 yrs.  
 Other conditions **Fracture of left femur Oct 27/40**

PHYSICIAN  
 Major findings: **none**  
 Of operations **none**  
 Of autopsy **none**  
 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 \_\_\_\_\_  
 28. Signature **A.P. Erich Schuch** (M. D. or other)  
 Address **St. Charles Mo.** Date signed **Nov 24/40**

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

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**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. Kane

Licensed Embalmer No. 3157

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.**

2B  
1-40  
K22859

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 39598  
Registrar's No. 199

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

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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

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~~ Mrs Katherine Blackmeier  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced wid  
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 86 Months 2 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) \_\_\_\_\_  
(Burial, cremation, or removal)

(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 11 day 20  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Broken Compensation  
Gen arteris sclerosis

Due to Chr nephritis

Due to Fract of left femur

Other conditions: (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations None

Of autopsy None

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) Accident

(b) Date of occurrence Oct 27 1940

(c) Where did injury occur? St. Charles St Charles, Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home

While at work? No (Specify type of place) (e) Means of injury A fall

23. Signatur A P Erieh Schuly (M. D. or other) \_\_\_\_\_  
Address St Charles, Mo Date signed 1/29/41

SUPPLEMENTAL COPY

MOTHER FATHER

1940

S-39598