

FEB FEB 18 1941

Registration District No. 257

Primary Registration District No. 3036

Registrar's No. 15

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
506 MORGAN ST. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 30 YEARS
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. 506 MORGAN ST
(If rural, give location) G
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 27
year 1941 hour _____ minute A M.?

21. I hereby certify that I attended the deceased from January 27, 1941, to January 29, 1941;
that I last saw him alive on January 28, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration 2 days

Due to _____

Due to _____

Other conditions myocardial disease
(Include pregnancy within 3 months of death)
generalized arteriosclerosis
1042
PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following: No

(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 George E. White (M. D. or other) MD

Address St Charles, Mo Date signed 2/29/41

8. (a) PRINT FULL NAME EDWARD A HEINRITZ

8. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 13 1875
(Month) (Day) (Year)

8. AGE: Years 65 Months 11 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace St Louis Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation Laborer

11. Industry or business _____

12. Name Chris Heinritz

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

14. Maiden name Margaret Schmidt

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

16. (a) Informant's own signature Henry A Keller

(b) Address 826 Washington St

17. (a) Burial (b) Date thereof Jan 31 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wright City Cem

18. (a) Signature of funeral director Wright City Cem

(b) Address Wright City Mo

19. (a) 1-29-41 (b) Colobwell B. Mosler
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

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.

932

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 Julius J. Nieburg
Licensed Embalmer No. 336-B
P. O. Address Wright City 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 4096

Registration District No. 757

Primary Registration District No. 3036

Registrar's No. _____

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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Edward A Keinritz

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 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 _____ year

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

8. AGE: Years 65 Months 11 Days 16 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) _____ (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 Jan day 27
year 1991 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 Pneumonia
lobar
Due to _____
Due to _____

Other conditions Myo Cardial Disease
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy no

Duration 2 days

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) no
(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 Gary S Keath (M. D. or other) MD
Address St Charles Mo Date signed _____

SUPPLEMENTAL

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

