

APR 11 1941

Registration District No. **257**

Primary Registration District No. **5998**

Registrar's No. **51**

1. PLACE OF DEATH:
(a) County **St. Charles**
(b) City or town **St. Charles - Rural**
(c) Name of hospital or institution: **Emmans Home**
(d) Length of stay: In hospital or institution **3 yrs 6 mo 28 Day**
In this community **0** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St Charles**
(c) City or town **Rural**
(d) Street No. **St Charles Township**
(e) If foreign born, how long in U. S. A.? **0** years.

3. (a) PRINT FULL NAME **CHARLOTTE STELLA M^c CLEARY**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or 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 **AUGUST 19 1918**
(Month) (Day) (Year)

8. AGE: Years **22** Months **6** Days **22** If less than one day _____ hr. _____ min.
9. Birthplace **ST. LOUIS MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name **FRED M^c CLEARY**
13. Birthplace **Not Known**
14. Maiden name **MARIE MEYER**
15. Birthplace **GERMANY**

16. (a) Informant **Theophil Stover**
(b) Address _____
17. (a) **Burial** (b) Date thereof **Mar 14 1941**
(c) Place: burial or cremation **St. Mathew Cemetery**
18. (a) Signature of funeral director **H. H. ...**
(b) Address **376 N 6th St. St Charles Mo**
19. (a) **3-13-41** (b) **Clarence G. Hesse**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **11** year **1941** hour **4** minute **-** P. M.
21. I hereby certify that I attended the deceased from **May 2nd 1937** to **March 11, 1941**
that I last saw her alive on **March 11, 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Intercranial hemorrhage**
Due to **Fracture of Skull**
Due to **Epilepsy**
Other conditions **18 in**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **Intercranial hemorrhage**
Of autopsy **Fracture Skull**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Accident**
(b) Date of occurrence **March 11th 1941**
(c) Where did injury occur? **St. Charles Co. Mo**
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Emmans Home
While at work? **Yes** (c) Means of injury **Fall**
23. Signature **Patrick Schuch** (M. D. or other) **5/12/41**
Address **St. Charles Mo** Date signed **5/12/41**

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

TV
8
0

92
0
0

Duration
5 hrs

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

NOV 9 1949

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. Hall*.....

Licensed Embalmer No. *13151*.....

P. O. Address *St. Charles, MD*.....

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, fact should be so stated above.

Registration District No. 757

Primary Registration District No. 5998

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles 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

Charlotte Stella McCleary

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
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 Months Days If less than one day
22 6 22 hr. min.

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

10. Usual occupation UNEMPLOYED FOR YEARS

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) June 7 1941 (b) Clarence S. Messer
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 11
year 1941 hour _____ minute _____ M.

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

Immediate cause of death _____ Duration _____
Died _____
Died _____

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?

While at work? (Specify type of place) _____ (e) Means of injury _____

23. Signature A. P. Erich Schuly (M. D. or other) _____

Address St Charles _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

11874

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.....

Licensed Embalmer No.....

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, fact should be so stated above.