

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26000**

Register's Office No. **AUG 15 1941**

Primary Registration District No. **3036**

Registrar's No. **118**

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: **St. Joseph Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 W 1 d**
(Specify whether
In this community **life**
years, months or days)

3. (a) PRINT FULL NAME **Magdalena Algermissen**

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 **widow**

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

7. Birth date of deceased **Sept. 17 1855**
(Month) (Day) (Year)

8. AGE: Years **85** Months **9** Days **0** If less than one day _____ hr. _____ min.

9. Birthplace **O'Fallon, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Lawrence Ernst**
13. Birthplace **Germany**
14. Maiden name **Magdalena Kirchhoff**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jos. L. Algermissen**
(b) Address **St. Peters, Mo.**

17. (a) **Burial** (b) Date thereof **6-20-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters, Mo.**

18. (a) Signature of funeral director **Geo. Stierwald**
(b) Address **St. Peters, Mo.**

19. (a) **6-19-41** (b) **Lawrence 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. Peters**
(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 **June** day **17**
year **1941** hour **8** minute **30** A. M.

21. I hereby certify that I attended the deceased from **May 5** 19**41** to **June 17** 19**41**;
that I last saw him alive on **June 17** 19**41**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial degeneration**

Due to **Senility**

Due to **Pyelitis**

Other conditions (Include pregnancy within 3 months of death)

Major findings:
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. Schneider** (M. D. or other) **MD**
Address **St. Charles, Mo.** Date signed **6/18/41**

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

APR 15 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 John E. Ballweyer
Licensed Embalmer No. 2951
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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26000

Registration District No. 757

Primary Registration District No. 3036

Registrar's No. 118

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 months
(Specify whether life - 85 yrs 9 mos
In this community years, months or days)

3. (a) PRINT FULL NAME Magdalena Algernissen

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

4. Sex M 5. Color or race Wh 6. (a) Single, widowed, married, divorced Wh

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 _____ 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-19-41 (b) Clarence B. Mueller

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Charles
(c) City or town St. Peters
(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 _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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)

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

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

