

Registration District No. 756Primary Registration District No. 4454

Registrar's No.

1. PLACE OF DEATH:

- (a) County St. Charles Postage Desiring
(b) City or town Rural - Postage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Postage De Sioux, Mo. 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 Lifetime
years, months or days)

3. (a) PRINT
FULL NAMEJerome Mallieux

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Rose (Hoffman) Mallieux
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased April 29 1866
(Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 27
If less than one day
..... hr. min.

9. Birthplace Postage De Sioux, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business.....

12. Name Frank Mallieux A
13. Birthplace Montreal Canada
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant William Mallieux
(b) Address Postage Des Sioux, Mo.

17. (a) Burial (b) Date thereof Nov. 29 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation St. Francis Cemetery Postage Des Sioux

18. (a) Signature of funeral director H.C. Hallmeyer & Sons Co.
(b) Address 800 N. Second, St. Charles, Mo.

19. (a) (Date received local registrar) (b) 6/1/41 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County St. Charles
(c) City or town Rural 930
(If outside city or town limits, write "RURAL")
(d) Street No. Postage Des Sioux, Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes/No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 26
year 1941 hour 10 minute 10 P.M.

21. I hereby certify that I attended the deceased from Sept 7
1940 to Nov 26 1941;
that I last saw him alive on Nov 26 1941;
and that death occurred on the date and hour stated above.

- Immediate cause of death
Chronic Myocarditis and
myocardial degeneration. Duration 5 years
Due to Bronchial Asthma. 15 years

- Other conditions
(Include pregnancy within 3 months of death) 930

- Major findings:
Of operations.....
Of autopsy.....

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?
(Specify type of place)
While at work?..... (e) Means of injury 0

23. Signature..... (M. D. or other).....
Address..... Date signed.....

STUCK INK
SE 1

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. Dallmeyer

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
21-41
229288

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39251

Registration District No. 756

Primary Registration District No. 4457

Registrar's No. _____

1. PLACE OF DEATH

(a) County St. Charles

(b) City or town Central
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jerome Malheur

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

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

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

Immediate cause of death _____

4. Sex M. 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 Apr. 29, 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	(If less than one day)
	<u>75</u>	<u>6</u>		min.

Due to _____

Due to _____

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

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)

Major findings: _____

Of operations _____

Of autopsy _____

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 C.A. Barnard

19. (a) Nov. 22/41 (b) C.A. Barnard
(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 C.A. Barnard (M. D. or other) _____

Address Postage Box 5100 Date signed Nov 28 1941

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

