

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

FILED MAR 2 1942
Registration District No. 757

Primary Registration District No. 3036

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: 803 Clay Street
(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 MISSOURI (b) County ST. CHARLES
(c) City or town ST. CHARLES
(If outside city or town limits, write "RURAL")
(d) Street No. 803 CLAY
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country U

3. (a) PRINT FULL NAME

Infant Stonebraker

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female / race White

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 January 11 1942
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	hr. _____ min. _____

9. Birthplace St. Charles Mo?
(City, town, or county) (State or foreign country)

10. Usual occupation ✓

11. Industry or business _____

12. Name Infant Stonebraker

13. Birthplace St. Charles Mo?
(City, town, or county) (State or foreign country)

14. Maiden name Anne Talbot

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

16. (a) Informant Mrs Stonebraker

(b) Address 803 Clay St., St. Charles, Mo

17. (a) Burial (b) Date thereof Jan 12 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem., St. Charles

18. (a) Signature of funeral director N.C. Dalmeyer & Sons Inc

(b) Address 800 N. Second, St. Charles, Mo

19. (a) 1-16-42 (b) Clarence T. Wessler
(Date received local registrar) (Registrar's signature)

677 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 12
year 1942 hour 12 minute 35 A. M.

21. I hereby certify that I attended the deceased from BIRTH
JANUARY 11 1942 to JANUARY 12 1942
that I last saw her alive on JANUARY 12 1942
and that death occurred on the date and hour stated above.

Immediate cause of death CARDIAC FAILURE Duration _____

Due to PREMATURITY

Due to _____

Other conditions CHILD WAS OF 6 1/2 MONTHS GESTATION

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 159

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 9

23. Signature W. F. L. Harrington (Date signed 1-14-1942)

Address St. Charles Mo (Date signed 1-14-1942)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

John E. Hallmeyer

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7681
Registrar's No.

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)

3. (a) PRINT FULL NAME Infant Stonebraker

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 s

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

7. Birth date of deceased Jan 11
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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. not available
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day _____
year 1942 hour _____ minute _____ M.

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

Due to Stillbirth

Due to _____

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)
(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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

