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X32873

Registration District No. 310 Primary Registration District No. 3058

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:
St. Joseph's Hospital
(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 Elizabeth Le Claire
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female / race White 5. Color or race _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if divorced Single

7. Birth date of deceased November 7 1942
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
12. Name Paul Le Claire, Jr.
13. Birthplace St. Charles Mo
(City, town, or county) (State or foreign country)
14. Maiden name Agnes Stilson
15. Birthplace St. Charles Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Paul Le Claire

(b) Address 1914 N. 25th, St. Charles, Mo

17. (a) Burial (b) Date thereof Nov 9 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles Business Cen

18. (a) Signature of funeral director W. C. Dallmeier & Sons

(b) Address 301 S. Second, St. Charles, Mo

19. (a) 11-8-42 (b) Clarence G. Wessler
(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 November 7
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Nov 6
1942 to Nov 7 1942
that I last saw her alive on Nov 6 1942
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Prematurity

Due to unknown

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)

(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. Schreiber (M. D. or other) MD

Address St. Charles, Mo Date signed Nov 10 42

Duration
159
Underline the cause to which death should be charged statistically.

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.....

Was not Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

John E Dallmeyer

Licensed Embalmer No..... *2957*

P. O. Address..... *St Charles Ill.*

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. 37903
Registrar's No. 416

Registration District No. 310 Primary Registration District No. 3058

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Joseph Hosp
(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 Elizabeth Le Claire
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month Feb Day 7 Year 1942 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I or saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
(Immediate cause of death _____)

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Feb 7
(Month) (Day) (Year)

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

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) 12-30-42 (b) Clarence G. Wessler
(Date received local registrar) (Registrar's signature)

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)
(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

MOTHER FATHER

SUPPLEMENTARY

