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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED DEC 10 1942

Registration District No. 370

Primary Registration District No. 3058

Registrar's No. 423

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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:
10 - East / Tompkins St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community nine months
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. 10 - East - Tompkins St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Gene Dale Schaffner

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

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 February 19 - 1942
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Thomas Schaffner
13. Birthplace St. Louis Arkansas
(City, town, or county) (State or foreign country)
14. Maiden name Florence Leona Sparks
15. Birthplace St. Louis County, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Schaffner

(b) Address 10 - East Tompkins, St. Charles, Mo.

17. (a) Burial (b) Date thereof 11-21-42
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director H.C. Dallmeyer & Sons, Co.

(b) Address 201 N. Second, St. Charles, Mo.

19. (a) 11-20-42 (b) Clarence J. Libeler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19
year 1942 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from Coroner's Viewing
that I last saw him alive on 11-21-42
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Cause unknown
Due to but due to
Due to natural causes.

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

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? _____

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

23. Signature H.P. Enich Schurz, M.D. (M. D. or other) _____
Address St. Charles, Mo. Date signed 12/1/42

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. Dalhmer
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 complete 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. 37961
Registrar's No. 423

Registration District No. 310 Primary Registration District No. 3058

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

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 Jern Dale Schaffner

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 Feb 19
(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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ 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 Status Thymico-lymphaticus
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?

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

23. Signature W. Erich Schuch (M.D. or other) _____

Address St Charles Mo Date signed 12/3/42

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

