

No. 2
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5-17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7430

State File No.

FILED MAR 11 1943
Registration District No. 370

Primary Registration District No. 3059

Registrar's No. 33

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:
237 Houston 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 Lifetime
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. 237 Houston St
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 12
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Jan 25
1943 to Feb 17 1943
that I last saw him alive on Jan 17 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor

Duration _____

Due to _____

Due to _____

Other conditions valvular heart disease,
(Include pregnancy within 3 months of death)
Baionasal sinus inf

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 Vernon A Schuber (M. D. or other) MD
Address St Charles, Mo Date signed 2/19/43

3. (a) PRINT FULL NAME Engine E Duman

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex male 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: September 7 1926
(Month) (Day) (Year)

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

16 5 10 hr. _____ min.

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

10. Usual occupation Student

11. Industry or business St. Charles High School

MOTHER FATHER

12. Name Nepolyte Duman

13. Birthplace Linn County, Mo
(City, town, or county) (State or foreign country)

14. Maiden name Henrietta Kaidel

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

16. (a) Informant Nepolyte Duman

(b) Address 237 Houston St, St. Charles, Mo

17. (a) Burial (b) Date thereof Feb 20 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles Rossmore Cem

18. (a) Signature of funeral director H. C. D. Allmeyer Sons Co

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

19. (a) 2-19-43 (b) Constance G. Wheeler
(Date received local registrar) (Registrar's Signature)

(Licensed Embalmer's Statement on Reverse Side)

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

3992

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 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. 7430
Registrar's No. 03

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)

3. (a) PRINT FULL NAME Eugene E. Dunn

3. (b) If veteran, name war No. 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 year

7. Birth date of deceased Sept 7 1907
(Month) (Day) (Year)

8. AGE: Years 16 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) (Date received local registrar) (b) (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 Feb Day 17
Year 1943 Hour Minute M.

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

Immediate cause of death Brian tumor Duration
inoperable malignant

Due to
Due to

Other conditions Valvular heart disease
(Include pregnancy within 3 months of death)

Major findings: Of operations 546

Of autopsy Refused 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 Wm Charles Dunn (M. D. or other) MD

Address St Charles Mo Date signed 4/1/43

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

MOTHER FATHER

SUPPLEMENTARY NO

