

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: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution One Week  
(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 92  
(If outside city or town limits, write "RURAL")  
(d) Street No. 428 Houston St. 9  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No) 3  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Julia C. Grace

3. (b) If veteran, name war \_\_\_\_\_

No

3. (c) Social Security No. \_\_\_\_\_

None

4. Sex Female race White

White

6. (a) Single, widowed, married, divorced \_\_\_\_\_

Married

6. (b) Name of husband or wife \_\_\_\_\_

Stephen C. Grace

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

60

7. Birth date of deceased \_\_\_\_\_

April 17 1890

(Month) (Day) (Year)

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

53 1 7 hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

Housewife

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

John Rose

13. Birthplace \_\_\_\_\_

Baden Mo. (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

Katherine Wenzmann

15. Birthplace \_\_\_\_\_

Bransburg Germany (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

Stephen C. Grace

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_

Burial May 28 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

St. Peter's Cem. St. Charles Mo.

18. (a) Signature of funeral director \_\_\_\_\_

H. C. Dallmeier

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_

5/31/43 Ernest C. Paul  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24  
year 1943 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from 5-1-41  
\_\_\_\_\_ 19\_\_\_\_ to 5-24-43  
\_\_\_\_\_ 19\_\_\_\_  
that I last saw he alive on 5-24-43  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Chr. Myocarditis & Degeneration 5 yrs

Due to \_\_\_\_\_  
Essential Hypertension 5 yrs

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 R. J. Brulle (M.D. or other) \_\_\_\_\_  
Address 200 Clay St. Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1340

AUG 7 1945

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. *2451* .....  
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.