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Registration District No. **310** Primary Registration District No. **3058** Registrar's No. **#96**

1. PLACE OF DEATH:

(a) County **St. Charles**  
(b) City or town  
(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  
In this community **40 yrs**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Charles**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **6020 Washington Avenue**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME

**PRED PANEITZ**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Etta Satler** 6. (c) Age of husband or wife if alive **73** years  
7. Birth date of deceased **8 22 1880**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>62</b>	<b>9</b>	<b>23</b>	hr. min.

9. Birthplace **German Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Storekeeper**

11. Industry or business **Century Electric**

12. Name **Pred Paneitz**  
13. Birthplace **Germany 4**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Germany 4**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Etta Paneitz**  
(b) Address **6020 Washington Avenue**

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

(c) Place: burial or cremation **St. Peters Cemetery**

18. (a) Signature of funeral director **Alexander & Sons, Inc.**  
(b) Address **6175 Delmar Blvd.**

19. (a) **June 18, 1943** (b) **Kernst E. Paule**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **15th** day **June**  
year **1943** hour **1** minute **45 P.M.**

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

Immediate cause of death

Due to **Suffocation due**

Due to **to drowning** **3 min**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operation **no**

Of autopsy **no**

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) **accident 072**

(b) Date of occurrence **June 15th 1943**

(c) Where did injury occur? **3 mi. N. orchard farm Mo**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**while fishing**

While at work? **no** (Specify type of place) (e) Means of injury **drowning**

23. Signature **G. Perich Schurz, M.D.**

Address **St. Charles Mo** Date signed **6/29/43**

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

MOTHER FATHER

1219

**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

*Arthur C. Davis*

Licensed Embalmer No.

*31151*

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
Registrar's No. 96

Registration District No. 310 Primary Registration District No. 2058

1. PLACE OF DEATH:

(a) County St Charles  
(b) City or town Postage On Sioux  
(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 Fred Parviz

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 M

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

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 62 Months 9 Days 23 If less than one day \_\_\_\_\_ or \_\_\_\_\_ 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) \_\_\_\_\_ (b) Conrad L. Paul (Registrar's signature)  
(Date received local registrar)

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 June year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

**SUPPLEMENTARY**

APR 17 1944

S-22274

APR 18 1944