

No. 2-43
17-39
X35697

FILED DEC 11 1943

Registration District No. **311**

Primary Registration District No. **6051**

Registrar's No. **190**

1. PLACE OF DEATH:

(a) County **ST. CHARLES**
(b) City or town **St. Charles**
(c) Name of hospital or institution: **EVANGELICAL EMMAUS HOME**
(d) Length of stay: In hospital or institution **6 YRS 2, MOS 26 D**
In this community **6 YRS 2, MOS 26 D**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS**
(c) City or town **BRENT WOOD**
(d) Street No. **8735 ROSALEE**
(e) Citizen of foreign country? **No.**

3. (a) PRINT FULL NAME **MARY SKOW**

(b) If veteran, name war. No. (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 **JULY 16, 1882**

8. AGE: Years **61** Months **3** Days **18** If less than one day hr. min.

9. Birthplace **MISSOURI**

10. Usual occupation **NONE**

11. Industry or business

MOTHER FATHER { 12. Name **PETER SKOW**
13. Birthplace **DENMARK**
14. Maiden name **ANNA M. NIELSON**
15. Birthplace **DENMARK**

16. (a) Informant **Therese Stoenen**
(b) Address **ST. CHARLES, MO**

17. (a) **BURIAL** (b) Date thereof **11-6-43**
(c) Place: burial or cremation **OPK. HILL CEM.**

18. (a) Signature of funeral director **James Smith**
(b) Address **Maplewood Mo.**
19. (a) **NOV. 5 1943** (b) **Samuel L. Pauw**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **4th** year **1943** hour **3** minute **15 M.**

21. I hereby certify that I attended the deceased from **Sept 11th** 1943 to **Nov 4th** 1943 that I last saw her, alive on **Nov 3rd** 1943 and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Sigmoid**
Due to **Hb 2**
Other conditions (Include pregnancy within 3 months of death)

Major findings: **Cancer of Sigmoid**
Of operations **Cancer of Sigmoid**
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature **Dr. P. F. Schuch**
Address **St. Charles Mo.**

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

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..... *V E Morris*

Licensed Embalmer No..... *9360*

P. O. Address.....

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.

Registration District No. 310 Primary Registration District No. 6051

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town Rural St. Charles, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Evangelical Emmaus Home
(If within hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 wks. 2 mo. 26 da.
(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 Mary Skow

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased July 16 1880
(Month) (Day) (Year)

8. AGE: Years 61 Months 3 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 _____ (City, town, or county) (State or foreign country)

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) 11-5-1943 (b) Emmet G. Paul
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day _____ Year 1943 Hour _____ minute _____ M.

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

Due to _____

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-39007