

FILED OCT 17 1944

Registration District No. 389

Primary Registration District No. 6049

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Charles
 (b) City or town Augusta, Mo.
 (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 Life years, months or days

3. (a) PRINT FULL NAME CHARLES MADLET

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

4. Sex M 5. Color or race N 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Dec. 31 1865
 (Month) (Day) (Year)

8. AGE: Years 78 Months 9 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace New melle Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name John Madler

13. Birthplace New melle Mo
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Meyer

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

16. (a) Informant Mrs. J. Madler
 (b) Address Augusta, Mo.

17. (a) Burial (b) Date thereof 9-28-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Luther Cemetery

18. (a) Signature of funeral director Mrs. J. Madler
 (b) Address Augusta, Mo.

19. (a) Sept 27 1944 (b) Viola Fluemeyer
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 26
 year 1944 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from JULY 12
1938 to SEPT 26 1944
 that I last saw him alive on SEPT 24 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Broncho pneumonia Duration 1 day
Chronic Myocarditis 6 yrs
Arteriosclerosis 8 yrs

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

Major findings:
 Of operations 93d
 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 Calvin C. Day (M. D. or other)
 Address Augusta Mo Date signed 9/26/44

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

MOTHER FATHER

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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 *M. Murchy # 2461*
Ch. Diering # 3759
Augustus
Licensed Embalmer No.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 200Registration District No. 307Primary Registration District No. 604-9A This is my old number
Registrar's No. _____

1. PLACE OF DEATH:

- (a) County St Charles
 (b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)
requests
 (c) Name of hospital or institution:
Fernme Osage Trp.
 (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 Charles Nadler

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 W

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

7. Birth date of deceased Dec 31 1860
(Month) (Day) (Year)8. AGE: Years 78 Months 9 Days 2 If less than one day _____ min.9. Birthplace _____ (City, town, or county) (State of foreign country) Mo.

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) OCT-23-1944 (b) Galena Clay MD
 (Date received local registrar) (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 Dec 1944 year _____ 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 _____

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?
 _____ (Specify type of place)
 _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

Duration

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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

SUPPLEMENTAL

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