

No. 2  
-8-43  
17-39  
X37823

FILED DEC 13 1944

Registration District No. **3**

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 **Lifetime**  
(Specify whether 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. **826 N. Fifth St.**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **GEORGE - H - SCHONE**

(b) If veteran, name war **No**

(c) Social Security No. **488-16-7505**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **1**  
year **1944** hour **7** minute **P.** M.

21. I hereby certify that I attended the deceased from **10/16/44**  
to **11/1/44** 19\_\_\_\_;  
that I last saw him alive on **11/1/44** 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Anna (Etting) Schone** 6. (c) Age of husband or wife if alive deceased years **18**

7. Birth date of deceased **August 18 1867**  
(Month) (Day) (Year)

Immediate cause of death **Cerebral Hemorrhage** Duration **16 days**

8. AGE: Years **77** Months **2** Days **13** If less than one day  
hr. min.

Due to **General Arterio Sclerosis** **20 years**

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

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

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

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

Major findings: **430**

-Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name **Richard G. Schone**

13. Birthplace **Unknown** 9  
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Eselmann**

15. Birthplace **Unknown** 9  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ralph Schone**

(b) Address **826 N. Fifth, St. Charles, Mo.**

17. (a) **Burial** (b) Date thereof **Nov 4-1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **W.C. Dalmeyer & Sons**

(b) Address **821 N. Second, St. Charles, Mo.**

19. (a) **11-4-1944** (b) **Conrad E. Paul**  
(Date received local registrar) (Registrar's signature)

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 **C. J. Bonard** (M. D. or other)

Address **St. Charles, Mo.** Date signed **11/3/44**

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

RECEIVED

District Health Officer: No. 9,

District File Number \_\_\_\_\_

Filed 12-12-44

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. 2964

P. O. Address H 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. dee

Registration District No. 310

Primary Registration District No. 3059

Registrar's No. 158

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 George H. Schone

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 \_\_\_\_\_

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

7. Birth date of deceased: Aug 18 1966  
(Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town or county) (State or foreign country)

10. Usual occupation SEAMAN

11. Industry or business Union, Co. Co.

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) \_\_\_\_\_ (b) Conrad C. Paulk  
(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 July year 1966 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 \_\_\_\_\_

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

MOTHER FATHER

Supplementary

38673

St Charles, Mo

Mr Smith & Parks