

No. 2
-2-43
-17-39
X35697

State File No. _____

FILED JAN 23 1945
Registration District No. 318

Primary Registration District No. 6051

Registrar's No. 184

1. PLACE OF DEATH:

(a) County ST. CHARLES.

(b) City or town ST. CHARLES, MISSOURI
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
EVANGELICAL EMMANUS HOME 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 YRS. 7 Mos. 17 DAYS
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 8522 HALLS FERRY RD.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CATHERINE TRAU SMITH

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex F 5. Color or race W.

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife JAMES T. SMITH

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

7. Birth date of deceased DECEMBER 19 1885
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>59</u>	<u>0</u>	<u>5</u>	hr. _____ min. _____

9. Birthplace (?) MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER

12. Name FRANK TRAU 4

13. Birthplace ELSACE LORRAINE GERMANY
(City, town, or county) (State or foreign country)

14. Maiden name KATHERINE BRUCKNER 4

15. Birthplace AUSTRIA 4
(City, town, or county) (State or foreign country)

16. (a) Informant Theophil Staercken 1

(b) Address ST. CHARLES, Mo.

17. (a) BURIAL (b) Date thereof 12/28/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WRIGHT CITY, Mo.

18. (a) Signature of funeral director MATH. FERNANN AND SON

(b) Address 2161 EAST FAIR AVE.

19. (a) 12-26-1944 (b) Ernest C. Paul
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 24
year 1944 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec. 23, 1944 to Dec. 24, 1944
that I last saw her alive on Dec. 24, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to hemorrhage of mucous membrane of mouth

Due to unknown origin

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

Major findings: Of operations 103

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?
(Specify type of place) _____

While at work? _____ (c) Means of injury _____

23. Signature W. P. Enich, Sheriff M. D. or other _____
Address St. Charles, Mo. Date signed 12/29/44

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

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed 1-20-45

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 Gustav W. Dittus
Licensed Embalmer No. 4329
P. O. Address St. Louis, 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.

Registration District No. 310

Primary Registration District No. 6051

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town RURAL ST CHARLES TWP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Evangelical Emmanuel Home
(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)

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

Catherine J. Smith

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

4. Sex F 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 19 (Month) (Day) (Year)

8. AGE: Years 59 Months 0 Days _____ (less than one day) min.

9. Birthplace _____ (City, town, or county) (State or 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) _____ (b) Ernest L. Paulk (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her 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) _____

Date signed _____

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

SUPPLEMENTARY

3223