

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31319**

FILED OCT 11 1945

Registration District No. **304**

Primary Registration District No. **6046**

Registrar's No. **5**

1. PLACE OF DEATH:

(a) County **St Charles**
(b) City or town **New Melle**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **New Melle**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None**
(Specify whether
In this community **Life**
years, months or days)

3. (a) PRINT FULL NAME **Kattie Auping**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **F** / 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **August Auping**
6. (c) Age of husband or wife if alive **71** years
7. Birth date of deceased **July 29, 1878**
(Month) (Day) (Year)

8. AGE: Years **67** Months **2** Days **6**
If less than one day hr. min.

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

10. Usual occupation **House Wife**

11. Industry or business _____

12. Name **William Alemling**
13. Birthplace **St Charels Co,**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Huning**
15. Birthplace **St Charles, Co**
(City, town, or county) (State or foreign country)

16. (a) Informant **August Auping**
(b) Address **New Melle, Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Oct. 8, 1945**
(Month) (Day) (Year)

(c) Place: burial or cremation **New Melle, Mo**

18. (a) Signature of funeral director **Marjorie M. Muehler**

(b) Address **New Melle, Mo**

19. (a) **Oct. 6, 1945** (Date received local registrar) (b) **Irene Rickman** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St Charles**
(c) City or town _____
(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 **Oct.** day **5**
year **1945** hour **9:00** minute _____ M.
21. I hereby certify that I attended the deceased from **7:00 P.**
_____ 19 **44** to **10/5** 19 **45**
that I last saw him alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Decompensation**
Reported Nephroses Duration **3 mo.**

Due to _____
Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **131/5**

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 **Kattie Auping** (M. D. or other) **WHD**
Address **New Melle, Mo** Date signed **10/6/45**

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 10-10-45

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.....

Marion Marchant

Licensed Embalmer No. 2461

P. O. Address Wentzville, 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.