

S. No. 2
M-8-43
5-17-39
P1 X37823

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED OCT 13 1945 STANDARD CERTIFICATE OF DEATH

31332

State File No. _____
Registrar's No. 120

Registration District No. 3/0 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's Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 2 Hours
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Charles 92
(c) City or town Rural (If outside city or town limits, write "RURAL") 0
(d) Street No. Rt. #1 (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Morris Jungermann
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 31, 1926
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
19 0 22 _____ hr. _____ min.

9. Birthplace St. Charles, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name William Jungermann
13. Birthplace St. Charles, Missouri 0
(City, town, or county) (State or foreign country)
14. Maiden name Cora Sc hierding
15. Birthplace St. Charles, Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant Wm Jungermann
(b) Address St Charles Mo

17. (a) Burial (b) Date thereof Aug. 26, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zion Lutheran Cemetery

18. (a) Signature of funeral director Naekmann - Baw

(b) Address 324 N 6th St. St. Charles Mo

19. (a) Aug 20, 1945 (b) Ernst G. Paul
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23
year 1945 hour 6 minute 10 P.M.
21. I hereby certify that I attended the deceased from 7/5, 1944 to 8/23, 1945
that I last saw h. alive on 8/23, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration
Chronic Sympthetic 4 Wks
(Leukosarcoma) acute cardiac failure 24 hours
Due to _____ ?
Due to _____ ?
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: _____
Of operations No _____
Of autopsy No _____
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 _____ (e) Means of injury _____
23. Signature ROH Syden (M. D. or other) MD
Address St Charles Mo Date signed 8/31/45

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 10-12-45

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 Arthur C. Bane

Licensed Embalmer No. 3154

P. O. Address St 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.