

S. No. 2
M-5-43
7-5-17-39
P-1 X3667

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38357

State File No. _____

Registrar's No. 253

FILED DEC 7 1945
Registration District No. 306

Primary Registration District No. 6048

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

1. PLACE OF DEATH:

(a) County ST. CHARLES
(b) City or town COTTLEVILLE
(c) Name of hospital or institution: 1
(d) Length of stay: In hospital or institution _____
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST. CHARLES
(c) City or town COTTLEVILLE
(d) Street No. _____
(e) Citizen of foreign country? NO

3. (a) PRINT FULL NAME JULIA SAUER
(b) If veteran, name war _____
(c) Social Security No. _____

20. DATE OF DEATH: Month Nov day 24
year 1945 hour 6 minute P M.

21. I hereby certify that I attended the deceased from June 1940 to Nov. 22 1945
that I last saw him alive on Nov. 22 1945
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife BEN SAUER
6. (c) Age of husband or wife if alive 89 years
7. Birth date of deceased SEPT. 27 1874

Immediate cause of death Coronary Thrombosis
Duration 5 min.

8. AGE: Years 70 Months 1 Days 25
If less than one day _____ hr. _____ min.

Due to Arterio sclerosis

9. Birthplace ST. CHARLES Co. MO

Due to _____

10. Usual occupation HOUSE WORK

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

11. Industry or business _____
12. Name PHILLIP VIERLING
13. Birthplace GERMANY
14. Maiden name SCHNEIDER
15. Birthplace ST. CHARLES Co. MO

Major findings: - Of operations 94%
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant BEN SAUER
(b) Address COTTLEVILLE MO

22. If death was due to external causes, fill in the following:

17. (a) BURIAL (b) Date thereof 11-25-45
(c) Place: burial or cremation COTTLEVILLE MO

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director E.A. Keathley
(b) Address O'FALLON MO

While at work? _____ (Specify type of place) _____
(c) Means of injury _____

19. (a) Nov. 25 1945 (b) E.A. Keathley
(Date received local registrar) (Registrar's signature)

23. Signature Nicholas J. Houch (M. D. or other) _____
Address O'Fallon, Mo. Date signed 11/28/45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 12-6-45

NOV 8 1955

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..... *E. Kelly*

Licensed Embalmer No. 822

P. O. Address Fallon 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.