

FILED DEC 7 1945

Registration District No. 310

Primary Registration District No. 2058

Registrar's No.

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  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 DAYS  
(Specify whether)

In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Charles

(c) City or town Wentzville Mo  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME George Sudbrock

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Nov 7 1945 to Nov 11 1945 that I last saw him alive on Nov 11 1945 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 MARRIED

7. Birth date of deceased: Sept. 18, 1868  
(Month) (Day) (Year)

Immediate cause of death: Pulmonary Edema  
Bronchial Asthma

Duration 2 day

8. AGE: Years Months Days If less than one day

77 1 24 hr. \_\_\_\_\_ min.

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

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

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

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

10. Usual occupation FARMER

Major findings: Of operations \_\_\_\_\_

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

Underline the cause to which death should be charged statistically.

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

12. Name FRANK Sudbrock

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

14. Maiden name Louise Bergelt

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

16. (a) Informant Elizabeth Sudbrock

(b) Address WENTZVILLE, Mo.

17. (a) BURIAL (b) Date thereof Nov. 13 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LINN CEMETERY WENTZVILLE Mo

18. (a) Signature of funeral director [Signature]

(b) Address WENTZVILLE Mo

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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) (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) MD

Address St Charles, Mo Date signed 12/12/45

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

MOTHER FATHER

284 J

RECEIVED  
District Health Officer No. 9,  
District File Number \_\_\_\_\_  
Date Filed 12-6-45

**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 \_\_\_\_\_  
Licensed Embalmer No. \_\_\_\_\_  
P. O. Address \_\_\_\_\_

**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. 38361

Registration District No. (319)

Primary Registration District No. (3058)

Registrar's No. \_\_\_\_\_

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 4 days  
(Specify whether)

In this community life  
years, months or days

3. (a) PRINT FULL NAME George Sudbrock

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 M

6. (b) Name of husband or wife Elyabeth

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

7. Birth date of deceased Sept 18 1894  
(Month) (Day) (Year)

8. AGE: Years 17 Months 2 Days 17  
If less than one day

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

10. Usual occupation Farmer

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

MOTHER FATHER

12. Name Frank Sudbrock

13. Birthplace German  
(City, town, or county) (State or foreign country)

14. Maiden name Louise Bergelt

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

16. (a) Informant Elyabeth Sudbrock

(b) Address Wentzville, Mo

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof 11-13-41  
(Month) (Day) (Year)

(c) Place: burial or cremation Lin Cemetery

18. (a) Signature of funeral director M. Munn

(b) Address Wentzville, Mo

19. (a) Jan 7-46 (b) Frank Hauert  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo

(b) County St Charles

(c) City or town Wentzville, Mo  
(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 \_\_\_\_\_ Year 1941 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema  
Bronchial Asthma 2 day

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

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

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

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

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

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

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 Vincenz A. Schneider  
(M.D. or other)

Address St Charles, Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

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

