

No. 2
5-43
5-17-39
X36671

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6881

State File No. _____
Registrar's No. 173

Registration District No. 310 Primary Registration District No. 305810091

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

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Dr. EMMAUS HOME 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 years
In this community 9 months - 7 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Louis 9/6
(c) City or town University City 3
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 5
(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 26
year 1946 hour 10 minute 55 A.M.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced ✓
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 11 1866
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 1946 to Feb 26, 1946
that I last saw her alive on Feb 25, 1946
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
79 3 19 hr. _____ min. _____

Immediate cause of death Hypostatic Congestion of Lungs
Due to _____ Duration _____

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

Due to Broken Compensation
Other conditions Gen Arterio-sclerosis
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings:
Of operations L
Of autopsy 9-7

11. Industry or business _____

12. Name JOSEPH ADLER 1 4

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

14. Maiden name Hermitta Bach

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

16. (a) Informant Frank Dreine

(b) Address 905 S. - Beau Villa St. Louis

17. (a) Burial (b) Date thereof 2/27/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int Simai

18. (a) Signature of funeral director Major
(b) Address 4336 Luedell St. St. Louis

19. (a) Feb 27/46 (b) Thomas H. Hamilton
(Date received local registrar) (Registrar's signature)

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 AP Erish Schuch (M. D. or other) _____
Address St. Charles Pub. Date signed 2/26/46

284 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number

Date Filed 3-12-46

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

John Agonovski

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.