

No. 2
1-5-39
I X388

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14217**

Registration District No. **310** Primary Registration District No. **3-0-5-8-605 /** Registrar's No. **72**

1. PLACE OF DEATH:
(a) County **ST. CHARLES**
(b) City or town **RURAL**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **EVANGELICAL EMMAUS HOME 5**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 YR. 11 MONTHS 7 DAYS**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **JOSEPHINE WEBER**
3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **MICHEL WEBER**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **JANUARY 15, 1863**
(Month) (Day) (Year)

8. AGE: Years **83** Months **2** Days **17**
If less than one day hr. _____ min. _____

9. Birthplace **AUSTRIA HUNGARY**
(City, town, or county) (State or foreign country)

10. Usual occupation **not able to work**

11. Industry or business _____
12. Name **HEINRICH BITTO**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Theophile Storsen**
(b) Address **ST. CHARLES, MO.**

17. (a) **Burial** (b) Date thereof **April 5, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Bland Mo.**

18. (a) Signature of funeral director **Huckemann - Bame**
(b) Address **St Charles Mo.**

19. (a) **April 29-46** (b) **Th Annie Hammett**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **37**
(c) City or town **BLAND** (If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No) **1**
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **APRIL** day **2**
year **1946** hour **5** minute **15 A. M.**
21. I hereby certify that I attended the deceased from **Mar 15th** 1946, to **April 2nd** 1946
that I last saw him alive on **April 1st** 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Acute dilatation of heart
Due to **Chronic Myocarditis**
Due to **Arteriosclerosis**
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy **gsk**

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? _____
Write at work? _____ (Specify type of place)
Means of injury _____
23. Signature **Dr. Eric Schuck** (M. D. or other) _____
Address **St Charles Mo** Date signed **4/5/46**

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

RECEIVED

District Health Officer. No. 9,

District File Number.....

Date Filed

5-13-46

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.....

Arthur E. Bane

Licensed Embalmer No. 3151

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.

Registration District No. 310

Primary Registration District No. 6051

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

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 15 (Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Mental Sewing
 11. Industry or business Not able to work.

MOTHER FATHER { 12. Name _____
 { 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 { 14. Maiden name _____
 { 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (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 August 2
 year 1946 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 _____

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

23. Signature _____ (M. D. or other)
 Address _____ Date signed _____

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

SUPPLEMENTARY

14217