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-17-39  
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**FILED** APR 17 1946  
Registration District No. **27**

Primary Registration District No. **6079**

Registrar's No. **76**

1. PLACE OF DEATH:  
(a) County **STE. GENEVIEVE**  
(b) City or town **STE. GENEVIEVE - Rural**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**COUNTY HOME 5**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 yrs**  
(Specify whether  
In this community **WIFE**  
years, months or days)

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

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **APRIL** day **3**  
year **1946** hour **1:15** minute **P** M.  
21. I hereby certify that I attended the deceased from **March 26**  
19**46**, to **April 3** 19**46**  
that I last saw h. **ER** alive on **April 3** 19**46**  
and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE**  
6. (a) Single, widowed, married, divorced **SINGLE**  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **MARCH 24 1866**  
(Month) (Day) (Year)

Immediate cause of death **Diabetes Mellitus**  
Duration **?**

8. AGE: Years **80** Months \_\_\_\_\_ Days **10**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions **Diabetes gangrene of left foot**  
(Include pregnancy within 3 months of death) **3/26/46**

9. Birthplace **ZELL MOU**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **no occupation**

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy **601**  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name **JOSEPH SCHMELZLE**  
13. Birthplace **GERMAN 44**  
(City, town, or county) (State or foreign country)  
14. Maiden name **THERESA QIESER**  
15. Birthplace **GERMAN 44**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Andrew Huber**  
(b) Address **St. Genevieve Mo Star # 2**  
17. (a) **BURIAL** (b) Date thereof **4-6-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **ZELL MO**

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)

18. (a) Signature of funeral director **J. C. Basler**  
(b) Address **St. Genevieve Mo**  
19. (a) **Apr. 6-46** (b) **Theresa M. Dail**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (e) Means of injury **60**  
23. Signature **J. C. Basler** (M. D. or D.O.)  
Address **St. Genevieve MO** Date signed **4/4/46**

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

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**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..... *Geo. C. Basler* .....

Licensed Embalmer No. *1985* .....

P. O. Address *St. Louis, 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. 219 Primary Registration District No. 6079

1. PLACE OF DEATH:  
(a) County St. Genevieve  
(b) City or town Paula  
(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

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Josephine Schmely  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased May 2 1876  
(Month) (Day) (Year)

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

8. AGE: Years 70 Months 50 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

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

10. Usual occupation Occupation of farm  
11. Industry or business Operator of family farm  
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)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) Teresa M. Karl  
(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) (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

TEMPORARY SUPPLEMENT

1937