No. 2, 5-43 17-39 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 20 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

21230

State File No.

Registration District No. 309 Primary Registration District No. 6050 Registrar's No.

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

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: Near Wilkie Station, (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Charles 93

(c) City or town Rural (If outside city or town limits, write "RURAL") 0

(d) Street No. Near Wilkie Station (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Jennie Paull

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct. (Month) 18, (Day) 1856 (Year)

8. AGE: Years 89 Months 7 Days 10 If less than one day hr. min.

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

10. Usual occupation Retired house widowed

11. Industry or business

FATHER
12. Name Jacob Woodward
13. Birthplace New York (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Shappell
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Francis Keisler

(b) Address St Charles R.F.D.3

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May, 31, 1946 (Month) (Day) (Year)

(c) Place: burial or cremation St Charles Oak Grove

18. (a) Signature of funeral director Maurice Murchison

(b) Address Wentzville, Mo

19. (a) 6-6-46 (Date received local registrar) (b) H. W. Grasser (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

21. I hereby certify that I attended the deceased from Aug. 19, 1945, to May. 26, 1946 that I last saw her alive on May. 26, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myo Carditis	10 years
Due to: General Arterio Sclerosis	25 years
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

97

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? St Charles Co. Mo (~~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 0

23. Signature C. A. Barnard (M. D. ~~or other~~)

Address St Charles. Mo Date signed 5/29/46

566 (Licensed Embalmer's Statement on Reverse Side)

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 Marie Muschany

Licensed Embalmer No. 2469

P. O. Address Wentzville

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.

No. 2B
X—3-45
P1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 309 Primary Registration District No. 6050 Registrar's No. 9

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

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 Jennie Paull

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 married

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 18 1856 (Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) 6-6-1946 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 29 year 1946 hour 12 minute 30 M.

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

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C. A. Barnard (M. D. or other)

Address St Charles Date signed 7/22/46

SUPPLEMENTARY

Ca
Lt Charles

21230