No. 2
2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31212

FILED SEP 17 1946

Registration District No. 37

Primary Registration District No. 3058

Registrar's No. 137

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's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Charles
(c) City or town St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 305 Jefferson Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Laura J. Linnemann
3. (b) If veteran, name war None
3. (c) Social Security No. None
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 July 22, 1873 (Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 13 If less than one day hr. min.

9. Birthplace St. Charles, (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housekeeper
11. Industry or business
FATHER
12. Name Henry Linnemann
13. Birthplace (City, town, or county) Germany (State or foreign country)
MOTHER
14. Maiden name Mathilda Bauser
15. Birthplace (City, town, or county) Germany (State or foreign country)
16. (a) Informant Katherine Linnemann
(b) Address St. Charles, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery
18. (a) Signature of funeral director Hackman Bauer Co
(b) Address 326 N. 6th. Str., St. Charles, Mo.
19. (a) 9-10-46 (Date received local registrar) (b) Fannie Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5 year 1946 hour 2 minute P. M.
21. I hereby certify that I attended the deceased from Aug. 15, 1946 to Sept. 5th, 1946 that I last saw him alive on Sept. 5th, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Uremia	3 days
Due to	
Due to Acute glomerular nephritis (Colon bacillus infection)	
Other conditions Chronic arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings:
Of operations ✓
Of autopsy ✓

30

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 10
23. Signature A. Erich Schulz M.D. (M.D. or other)
Address St. Charles Mo. Date signed 9/1/46

284 (Licensed Embalmer's Statement on Reverse Side)

NOV 8 1946

FEB 11 1947

RECEIVED
District Health Officer No. 9
District File Number 9-46-127
Date Filed 9-16-46

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 C. Bauer

Licensed Embalmer No. 3155

P. O. Address St Charles M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
M—3-45
I 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. Oct

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 187

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:

(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 Laura J. Linnemann

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased July 22 (Month) (Day) 1873 (Year)

8. AGE: Years 73 Months 1 Days 13 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) Sept 10-46 (Date received local registrar) (b) Francis Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1946 hour minute 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

31212

FEB 11 1947

NOV 8 1947