DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 23 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34542

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 153

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

(d) Length of stay: In hospital or institution 11 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles 9-2

(c) City or town St. Charles (If outside city or town limits, write "RURAL") 9

(d) Street No. 723 Clay Street (If rural, give location) 3

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

If yes, name country

3. (a) PRINT FULL NAME John Iler

3. (b) If veteran, name war NIL

3. (c) Social Security No. NIL

4. Sex Male 6

5. Color or race White

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

6. (b) Name of husband or wife Caroline(Weber)Iler

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased October (Month) 4 (Day) 1866 (Year)

8. AGE: Years 80 Months 0 Days 10 If less than one day hr. min.

9. Birthplace O'Fallon (City, town, or county) Missouri (State or foreign country) 1

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name William Iler 0
13. Birthplace O'Fallon (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Caroline Audrain 0
15. Birthplace O'Fallon (City, town, or county) Missouri (State or foreign country)

16. (a) Informant F.L. Kapeller & H.R. Ellis

(b) Address St. Louis, Missouri

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Oct 17-1946 (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles Borromeo St. Charles, Mo.

18. (a) Signature of funeral director H.C. Dallmeyer & Sons Co

(b) Address 800 N. 2nd-St.Charles, Mo.

19. (a) 10/17/46 (Date received local registrar) (b) Fannie Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14 year 1946 hour 10:40 minute P. M.

21. I hereby certify that I attended the deceased from 10/3 1946 to 10/14 1946 that I last saw him alive on 10/14 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic pneumonia	1 wk.
Due to Bedridden	
Due to Fracture of thigh	
Other conditions Senility (Include pregnancy within 3 months of death)	

Major findings: Of operations none

Of autopsy none

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 730

(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 0

23. Signature [signature] (M. D. or other) [illegible]

Address St. Charles, Mo. Date signed 10/16/46

284 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 91
District File Number
Date Filed 10-22-46

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 Joseph I Landsee

Licensed Embalmer No. 4189

P. O. Address St. Louis

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

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

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THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 153

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
In this community 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 John Iler

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 4 (Day) 1866 (Year)

8. AGE: Years 80 Months 0 Days 0 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct day 14
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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 186A
Of autopsy 18

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) accident

(b) Date of occurrence 10/3/46

(c) Where did injury occur? St. Charles (City or town) St Charles (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on the street (walking) (Specify type of place)
While at work? no (e) Means of injury Fall

23. Signature [illegible] (M. D. or other)
Address St. Charles, Mo Date signed 10/30/46

SUPPLEMENTARY

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

33365

34542