

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED MAR 11 1947

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

5867

1. PLACE OF DEATH

County St. Charles

Registration District No. 310

Township

City St. Charles

(No. 1)

Primary Registration District No. 3058

File No.

Registered No. 42

St.

Ward

2. FULL NAME

No Name Ahlmeyer

(a) Residence, No.

St.

Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, ... hrs.
or 20 min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.

9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.

10. Date deceased last worked at
this occupation (month and
year)

11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

St. Charles, Mo.

FATHER

13. NAME

Morris Carl Ahlmeyer

14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

St. Louis, Mo.

MOTHER

15. MAIDEN NAME

Elizabeth L. Johnson

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

DeFiance, Mo.

17. INFORMANT
(ADDRESS)

Mrs. P. Johnson
DeFiance, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE DeFiance, Mo. DATE Feb 23, 1947

19. UNDERTAKER
(ADDRESS)

Marion Muehlberg
St. Charles, Mo.

20. FILED

3/4/47, 1947, F. Annis Hamilton
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

1947

22. I HEREBY CERTIFY, That I attended deceased from

Feb 25, 1947, to Feb 25, 1947

I last saw him alive on February 25, 1947. Death is said
to have occurred on the date stated above, at 17:30 A.M.

The principal cause of death and related causes of importance were as follows:

Congenital abscess - rectum,
infection & external genital,
club foot.

Date of onset

Other contributory causes of importance:

Premature -

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Wm. A. Schenck

M. D.

(Address)

St. Charles, Mo.

RECEIVED
District Health Officer No. 9,
District File Number
MAR 7 1947
Date Filed

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 42

Registration District No. 310 Primary Registration District No. 3058

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)

3. (a) PRINT FULL NAME

Infant Ahlmeyer
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 5
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased March 3 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (Less than one day _____ hr. _____ min. 20 mo)

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) 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 March year 1947 hour _____ minute _____ M.

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

Immediate cause of death Congenital Defect
Esophageal atresia, rectum, efflux at genitals, bladder.

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? _____

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

23. Signature Vincent A. Schneider (M. D. or other) MD

Address St Charles, Mo Date signed 3/11/47

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

SUPPLEMENTARY

S-5867