

No. 2
-12-45
-5-17-39
118X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 21 1947
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10414
Registrar's No. 45

Registration District No. 310 Primary Registration District No. 6051

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town "Rural" St. Charles Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Charles County Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 years
(Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Francis J. Hollander
3. (b) If veteran, name war NIL 3. (c) Social Security No. NIL

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased ? 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 ? ? hr. min.

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

10. Usual occupation Retired laborer

11. Industry or business _____

MOTHER FATHER
12. Name unknown
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Wm Rommelmann, Supt.
(b) Address St. Charles County Home

17. (a) burial (b) Date thereof Feb 28-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Peter Cem, St. Charles, Mo.

18. (a) Signature of funeral director H. O. Ballmeier + Donald
(b) Address 800 N. 2nd-St. Charles, Mo.

19. (a) 3-1-47 (b) Janice Hamilton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 26
year 1947 hour 8 minute 0 A. M.
21. I hereby certify that I attended the deceased from Feb 24 1947 to Feb 26 1947
that I last saw him alive on Feb 25 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration 2 days
Due to Broken Compensation
Due to Ren Arterio sclerosis 1947
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? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 2
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature A. P. Erickson (M. D. or other) MD
Address St Charles Mo Date signed 2/27/47

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

AUG 19 1946

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 3/20/47

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 F. Lambert*
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 with the above constitutes grounds for revocation of license.)

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

Registration District No. 310 Primary Registration District No. 6051

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)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Francis J. Hollander
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 _____
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: 81 Years Months Days hr. min. (Unless than one day)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

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

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

19. (a) March 1-47 (b) Francis Hollander
(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 February year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

10414