No. 2
12-45
17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 7 1947

Registration District No. 386

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6048

State File No. 25173

Registrar's No. 279

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town O'Fallon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Institute
(If not in hospital or institution, write street number or location)

(d) Length of stay: In ~~hospital~~ or institution 57 years (Specify whether
In this community 57 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles 92

(c) City or town O'Fallon
(If outside city or town limits, write "RURAL")

(d) Street No. St. Mary's Institute
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Sister Gregory Maise, C.PP.S.

3. (b) If veteran, name war

3. (c) Social Security No.

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 September 11, 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
76	10	18	hr. min.

9. Birthplace Schaschen (City, town, or county) Germany 4 (State or foreign country)

10. Usual occupation Teacher

11. Industry or business

FATHER
12. Name Benedict Maise
13. Birthplace Niederwil, Baden, Germany 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Regine Ebner
15. Birthplace Shaschen, Baden, Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Sister M. Dominica, C.PP.S.
(b) Address O'Fallon, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1, 1947
(Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ 66 O'Fallon, Missouri

18. (a) Signature of funeral director McDallmeyer
(b) Address 800 N. 2nd St.

19. (a) July 31 -47 (Date received local registrar) E A Keithly (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1947 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 1947 to July 29, 1947
that I last saw her alive on 26 July 1947
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
chronic myocarditis	10 yrs
Due to generalized arteriosclerosis	
Due to	
Other conditions intertrochanteric fracture left femur (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

186 A

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

22. If death was due to external causes, fill in the following: 92
(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 Lawrence G Behan MD (M. D. or other)
Address O'Fallon Mo Date signed 31 July 47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number 5-6-47
Date Filed

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 Landolt

Licensed Embalmer No. 4189

P. O. Address St Charles Mo

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
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

25113

State File No. aug

Registration District No. 306 Primary Registration District No. 6048 Registrar's No. 279

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town O'Fallon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Marys Institute
(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: Sister Gregory Maise

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 Sept 11 1879
(Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 18 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Germany (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 July 29
year 1947 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
chronic myocarditis	5 yrs
Due to generalized arteriosclerosis	10 yrs
Due to fracture left femur intertrochanteric	3 da
Other conditions (Include pregnancy within 3 months of death)	

186A
14
10

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) accident

(b) Date of occurrence July 26-47

(c) Where did injury occur? O'Fallon Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home
(Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature L G Behan MD (M. D. or other)

Address O'Fallon Mo. Date signed 8-30-47

SUPPLEMENTARY

S-25174