

12-45
5-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 30 1948

UNITED STATES DEPARTMENT OF HEALTH OF THE UNITED STATES
STANDARD CERTIFICATE OF DEATH

State File No. **2147**
Registrar's No. **19**

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:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days** (Specify whether
In this community **76 years** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Charles**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Rt. #3** (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Marie Louise Wiedey**
(b) If veteran, name war (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **10**
year **1948** hour **3** minute **10** P. M.
21. I hereby certify that I attended the deceased from
December 4 19**47** to **January 10** 19**48**
that I last saw her alive on **January 10** 19**48**
and that death occurred on the date and hour stated above.

4. Sex **F** / race **W** 5. Color or
6. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **William Wiedey** (c) Age of husband or wife if
alive **78** years
7. Birth date of deceased **July 15 1871**
(Month) (Day) (Year)

Immediate cause of death **Broncho-pneumonia** Duration **2 wks**
Due to
Due to

8. AGE: Years Months Days If less than one day
76 5 25 hr. min.

Other conditions **thyroid adenoma** **5074**
(Include pregnancy within 6 months of death) **6070**
myocardial disease **PHYSICIAN**
Major findings:
Of operations
Of autopsy **107**
Underline the cause to which death should be charged statistically.

9. Birthplace **St. Charles Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **House keeper**
Home

11. Industry or business
12. Name **Henry Kohrs**
13. Birthplace **Geramny**
(City, town, or county) (State or foreign country)
14. Maiden name **Charlotte Lohmeier**
15. Birthplace **Geramny**
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant **Willeim Wiedey**
(b) Address **St Charles Rt 3**

17. (a) **Burial** (b) Date thereof **Jan 13 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Johns Cemetery**

18. (a) Signature of funeral director **Huckmann - Brown**
(b) Address **326 North 6th St St Charles Mo**
19. (a) **Jan 27 48** (b) **Franie Hamilton**
Date received local registrar (Registrar's signature)

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 **George E. Kiehn** (M. D. or other) **Mal**
Address **St. Charles Mo** Date signed **1-13-48**

Date Filed JAN 29 1978

License File Number

Sanitary Health Officer No. 9

RECEIVED

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. Bane*

Licensed Embalmer No. *9154*

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.