

No. 2
8-43
17-39
23823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 10 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9876

Registration District No. 305

Primary Registration District No. 6547

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town Flint Hill
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Life _____ (Specify whether _____)
years, months or days 84 yrs 2 3 da

3. (a) PRINT FULL NAME August A. Peime Jr.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single widowed, married, divorced

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 27 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
8 9 23 hr. min.

9. Birthplace Flint Hill Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name August Peime

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

14. Maiden name Marie Brad

15. Birthplace Flint Hill Mo
(City, town, or county) (State or foreign country)

16. (a) Informant August Peime

(b) Address Flint Hill Mo

17. (a) Burial (b) Date thereof 3-17-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flint Hill Mo

18. (a) Signature of funeral director H. A. Peterson

(b) Address Wentzville Mo

19. (a) _____ (b) Martin Puff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Charles
(c) City or town Flint Hill Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Mar. day 22.
year 1948 hour 3:40 minute A. M.

21. I hereby certify that I attended the deceased from Jan. 1948 to Mar. 1948
that I last saw him alive on 3/21 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Idiopathic intracranial hemorrhage Duration 8 Mos.

Due to _____

Due to _____

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

Major findings:
Of operations gross
Of autopsy gross

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 0

Signature H. C. McCoy Murray M.D. or other _____

Address Wentzville Mo Date signed 3/22/48

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

X-

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 4-8-48

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.....
T. E. Plumer

Licensed Embalmer No. 2711

P. O. Address Wentzville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. apud
Registrar's No. _____

Registration District No. 305 Primary Registration District No. 6047

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town St Charles
(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 August A. Peine Jr
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May Day 22 year 1948 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 _____

4. Sex M 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 _____

7. Birth date of deceased May 2 (Month) 19 (Day) 19 (Year)
8. AGE: 8 Years 9 Months 13 Days If less than one day _____ hr. _____ min.

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

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

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

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

S-9876