

FILED JUN 18 1948

Registration District No. 279

Primary Registration District No. 4469

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Ste. Genevieve
(b) City or town Ste. Genevieve
(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 Florence M. Hogenmiller

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 Married

(b) Name of husband or wife Charles Hogenmiller 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased October 12 1890
(Month) (Day) (Year)

8. AGE: Years 57 Months 7 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Peter P. Fallert

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

14. Maiden name Catherine Barter

15. Birthplace Buffalo New York
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Hogenmiller

(b) Address Ste. Genevieve, Missouri

17. (a) Burial (b) Date thereof May 29, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ste. Genevieve, Missouri

18. (a) Signature of funeral director James H. South

(b) Address Ste. Genevieve, Missouri

19. (a) 5-29-48 (b) Tereso M. Karl
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ste. Genevieve

(c) City or town Ste. Genevieve
(If outside city or town limits, write "RURAL")

(d) Street No. 797 Jefferson
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26
year 1948 hour 3 minute 50 P.M.

21. I hereby certify that I attended the deceased from Jan. 1947
19____, to May 26 1948, 19____;

that I last saw her alive on May 26 1948, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Acute Cardiac Dilatation.

Pulmonary Oedema

Due to Hydrothorax

Carcinoma of Breast

Due to _____

Other conditions Secondary Anemia
(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma of Breast

Of autopsy LD

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(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 W. G. Lapassade (M. D. or other) MD

Address Ste. Genevieve Mo. Date signed 5-27-48

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

MOTHER FATHER

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

RECEIVED

Health Officer No. _____
File Number 648
Date Filed 6-12-

MAR 22 1961

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 Jerome H. Scanton
Licensed Embalmer No. 3817
P. O. Address Sta. Genevieve, Ill.

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. 319

Primary Registration District No. 4469

Registrar's No.

1. PLACE OF DEATH:

(a) County Ste Genevieve
(b) City or town Ste Genevieve
(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 Florence M. Hogenmuller

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 M

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

7. Birth date of deceased Oct 12 1899
(Month) (Day) (Year)

8. AGE: Years 57 Months 7 Days _____ (If less than one day _____ min.)

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) _____ (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) 5-29-48 (Date received local registrar) (b) Teresa M. Karl (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 _____ Year 1948 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MOTHER FATHER

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

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