

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

23961

FILED AUG 5 1948

Registration District No. 310

Primary Registration District No. 3058

Registrar's No.

138

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:
210 South Kingshighway
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **22 years**
years, months or days)

3. (a) PRINT FULL NAME **Dr. Paul I. Mallinckrodt**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **August 2 1891**
(Month) (Day) (Year)

8. AGE: Years **56** Months **11** Days **6** If less than one day hr. min.

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

10. Usual occupation **Dentist**

11. Industry or business _____

12. Name **Berthold Mallinckrodt**

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

14. Maiden name **Emma Slem**

15. Birthplace **Augusta Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. Paul Mallinckrodt Jr.**

(b) Address **Washington Mo.**

17. (a) **Burial** (b) Date thereof **July 13 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove**

18. (a) Signature of funeral director **Wishmann, Rose**

(b) Address **326 No. 6th St St Charles Mo.**

19. (a) **July 2 6/48** (b) **Ramie Hamilton**
(Date received, local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Charles**
(c) City or town **St. Charles**
(If outside city or town limits, write "RURAL")
(d) Street No. **210 So. Kingshighway**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8th** year **1948** hour **7** minute **P.** M.

21. I hereby certify that I attended the deceased from **July 1 1948** to **July 8 1948** that I last saw him alive on **July 8 1948** and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Coronary occlusion

Due to _____

Gen. Arterio Sclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death)

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) _____

(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) (c) Means of injury _____

Signature **U.P. Erich Schaub** (Name of other) _____

Address **St. Charles Mo.** Date signed **7/5/48**

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed AUG 2 1948

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.....

Freddie W. Bane....., Registered Apprentice No. 510
working under my personal supervision.

Signed..... *Arthur C. Bane*
Licensed Embalmer No. 314-1
P. O. Address..... *St. Charles, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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