

**FILED AUG 10 1948**  
1940

Registration District No. \_\_\_\_\_ Primary Registration District No. **30586051** Registrar's No. **151**

**1. PLACE OF DEATH:**

(a) County **St. Charles**  
(b) City or town **Rural**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Rural Rt 3 St Charles Co 3**  
(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 **Missouri** (b) County **St. Louis** **96**  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") **3**  
(d) Street No. **7512 Page Blvd.** (If rural, give location) **1**  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **FRANK V. HORSTMAN**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **329-07-2927**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Hester F. Horstman** 6. (c) Age of husband or wife if alive **48** years

7. Birth date of deceased **September 14 1898**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>49</b>	<b>10</b>	<b>8</b>	hr. _____ min.

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

10. Usual occupation **Works Manager**

11. Industry or business **American Magnesium Works**

MOTHER FATHER { 12. Name **Louis Horstman**

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

14. Maiden names **Josephine Quieller**

15. Birthplace **St Louis Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Hester F. Horstman**

(b) Address **7512 Page Ave**

17. (a) **Burial** (b) Date thereof **July 26 1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **C.R. LUPTON & SONS**

(b) Address **7233 Delmar**

19. (a) **Aug 2-1948** (b) **Francis Hamelton**  
(Day received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH, Month **July** day **22**  
**1948** year hour **4** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **xxxxxxx** held and  
**quest July 24, 1948**, 19\_\_\_\_

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death **BRANKING**  
**Drowning**

Due to **Accident drowning**

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations **103**  
**1036**  
Of autopsy **None**

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** **9.2**

(b) Date of occurrence **July 22, 1948**

(c) Where did injury occur? **Mississippi river in St. Charles Co.** (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**public place** **3**

While at work? **NO** (Specify type of place) (e) Means of injury **Drowning**

Signature **Meriam Muehler** Date signed **7-24-48**  
Address **Montgomeryville Mo**

Date Filed AUG 9 1948

District File Number

District Health Officer No. 9,

RECEIVED

AUG 10 1948

APR 9 1956

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

*Arnold W. Schone*

Licensed Embalmer No.

3864

P. O. Address

*St Louis, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Aug  
Registrar's No. 1510

Registration District No. 310

Primary Registration District No. 3058

1. PLACE OF DEATH:  
(a) County St Charles  
(b) City or town Rural  
(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)

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 Frank O. Workman

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

4. Sex m 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 \_\_\_\_\_ years

7. Birth date of deceased Sept 14 1883  
(Month) (Day) (Year)

8. AGE: Years 49 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day hr. \_\_\_\_\_ 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature Wendyville (M.D. or D.P.H.) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 8-14-48

SUPPLEMENTARY

No. 3058

MOTHER FATHER

S-23983