

BUREAU OF THE CENSUS  
FILED AUG 25 1948Registration District No. 310Primary Registration District No. 3058Registrar's No. 165

## 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 4 weeks  
 (Specify whether years, months or days) Life

3. (a) PRINT FULL NAME EUGENIE KEMNER

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 widowed

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

7. Birth date of deceased June 8, 1879  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
69 2 3 hr. min.9. Birthplace Augusta, Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation House Work

11. Industry or business.....

12. Name Herman Meinershagen13. Birthplace Femme Osage  
(City, town, or county) (State or foreign country)14. Maiden name Anna Brahm15. Birthplace Germany  
(City, town, or county) (State or foreign country)16. (a) Informant Dan Kemner(b) Address Augusta Mo17. (a) Burial (b) Date thereof 8-14-48  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Augusta18. (a) Signature of funeral director Marian M... ..(b) Address W... ..19. (a) Aug 19-48 (b) Francis Hammett  
(Date received by local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Charles  
 (c) City or town Rural  
 (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 AUG day 12  
year 1948 hour 3 minute A M.21. I hereby certify that I attended the deceased from JULY 7, 1948, to AUG 12, 1948  
that I last saw her alive on AUG 11, 1948  
and that death occurred on the date and hour stated above.Immediate cause of death ORDINARY OCCLUSION  
Due to POST OPERATIVEOther conditions ADENOCARCINOMA OF LEFT BREAST  
(Include pregnancy within 5 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 Galvin Ely (M. D. or other) M.D.  
Address ST. CHARLES Date signed 8/17/48

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed AUG 22 1913

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.....

Howard O Kessler....., Registered Apprentice No. 201  
working under my personal supervision.

Signed Marion Muehling  
Licensed Embalmer No. 2461  
P. O. Address Wentzville

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

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

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 165

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:

(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 Eugene J. Kemmer

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 wid

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

7. Birth date of deceased June 9 (Month) (Day) (Year)

8. AGE: Years 69 Months \_\_\_\_\_ 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 \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St Charles

(c) City or town Rural (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 \_\_\_\_\_ 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

B  
15  
3880

S-27394