

No. 2
12-55
17-39
47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 15 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27402
Registrar's No. 124

Registration District No. 310

Primary Registration District No. 30-586051

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

1. PLACE OF DEATH:
 (a) County St. Charles
 (b) City or town Beenslick Road *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 _____
 In this community 78 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Charles *92*
 (c) City or town Beenslick Road *0*
(If outside city or town limits, write "RURAL") *0*
 (d) Street No. _____
(If rural, give location) *0*
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Edward A Greiwe
 3. (b) If veteran, name war none
 3. (c) Social Security No. none
 4. Sex M *U* 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Sophia
 6. (c) Age of husband or wife if alive 76 years
 7. Birth date of deceased Jan 1870
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month JUNE day 25
 year 1948 hour 9 minute 15A M.
 21. I hereby certify that I attended the deceased from JAN-1945
 _____, 19____, to _____, 19____
 that I last saw him alive on JUNE 8, 1948
 and that death occurred on the date and hour stated above.
 Immediate cause of death CORONARY OCCLUSION *Duration*

8. AGE: Years 78 Months 5 Days 19
 If less than one day _____ hr. _____ min.

Due to CHRONIC MYOCARDITIS
SECONDARY ANEMIA

9. Birthplace New Melle Mo. *U*
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation Retired

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

11. Industry or business _____

Major findings:
 Of operations _____
 Of autopsy _____

MOTHER FATHER { 12. Name Frederick Greiwe

13. Birthplace New Melle Mo. *U*
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Toedebush

15. Birthplace New Melle Mo. *U*
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
932

16. (a) Informant Mrs. Sophia Greiwe

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

(b) Address Beenslick Road

17. (a) _____ (b) Date thereof June 27 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lutheran Cemetery

(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? _____

18. (a) Signature of funeral director Hackmann Bauer

While at work? _____
(Specify type of place) (c) Means of injury.

(b) Address 326 North W. St. Charles, MO

19. (a) 7/6/48 (b) Pauline Bruner
(Date received local registrar) (Registrar's signature)

23. Signature Dr. F. L. Harrington
 Address St. Charles, Mo. Date signed 6-25-48

RECEIVED
District Health Officer No. 9,
District File Number
JUL 14 1948
Date Filed

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.....

Frederic M. Bane....., Registered Apprentice No. *510*
working under my personal supervision.

Signed.....*Arthur C. Bane*.....

Licensed Embalmer No. *3145*

P. O. Address *St Charles 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.

Registration District No. 310

Primary Registration District No. 6051

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town Rural R. # 2 - 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) (Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Charles
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. Rural R. # 2 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Edward A. Greiner

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 _____

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 78 Months _____ Days _____ (Unless than one day) hr. _____ min. _____

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

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)

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.

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

SUPPLEMENTARY

S-27402