

FILED MAY 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16973

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles	
c. LENGTH OF STAY (in this place) Life time		d. STREET ADDRESS (If rural, give location) 909 Madison Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION 909 Madison Street			

3. NAME OF DECEASED (Type or Print) a. (First) Philomina	b. (Middle) -----	c. (Last) Sullentrop	4. DATE OF DEATH (Month) (Day) (Year) May 11 1949
--	-------------------	-----------------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH December 10-1865	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	---	--	---	-----------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) St. Charles County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	--	--

13a. FATHER'S NAME Peter Boschert	13b. MOTHER'S MAIDEN NAME ??? Weber	14. NAME OF HUSBAND OR WIFE Frank Sullentrop, dec'd
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. NIL	17. INFORMANT'S SIGNATURE OR NAME Lester Sullentrop(son)	ADDRESS St. Charles, Mo.
---	------------------------------------	---	---------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 331X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Sclerosis		
	DUE TO (c) Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from May 8, 1949, to May 11, 1949, that I last saw the deceased alive on May 11, 1949 and that death occurred at 3:30 Am., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i> (Degree or title) M.D.	23b. ADDRESS St. Charles, Mo.	23c. DATE SIGNED 5-12-49
---	--------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 13-1949	24c. NAME OF CEMETERY OR CREMATORY St. Peter Cemetery	24d. LOCATION (City, town, or county) (State) St. Charles, Missouri
---	------------------------------	--	--

DATE REC'D BY LOCAL REG. 5-4-49	REGISTRAR'S SIGNATURE Fannie Hamilton	25. FUNERAL DIRECTOR'S SIGNATURE H. C. Dallmeyer & Sons Co	ADDRESS 800 N. 2nd St. Charles, Mo.
--	--	---	--

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed MAY 18 1949

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 me

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Joseph F. Wendt

Licensed Embalmer No. 4189

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.