

FILED SEP 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27764  
162

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Charles</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Charles</b>	
c. LENGTH OF STAY (In this place) <b>Life time</b>		92	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>1718 North Second Street 2</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Sophia</b>	b. (Middle) <b>-----</b>	c. (Last) <b>Pallardy</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>September 6-1949</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 27-1857</b>	9. AGE (In years last birthday) <b>92</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	11. BIRTHPLACE (State or foreign country) <b>St. Charles, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>unknown Kretzer</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Paul D. Pallardy</b>	<b>dec'd 1934</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>NIL</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Mayme Osner-St. Charles, Mo.</b>	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>congestive heart failure pulmonary edema</b>		<b>2 days</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Fracture right hip.</b>		<b>Es 9040</b> <b>21</b>
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"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St Charles St Charles Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Sept 1 1949 9A</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fall</b>
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22. I hereby certify that I attended the deceased from **Aug**, 1949, to **Sept 8**, 1949, that I last saw the deceased alive on **Sept 8**, 1949, and that death occurred at **10:30 A**, from the causes and on the date stated above.

23a. SIGNATURE <b>Vaschneider</b>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>St Charles Mo</b>	23c. DATE SIGNED <b>Sept 7-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sept 8-1949</b>	24c. NAME OF CEMETERY <b>St. Charles Borromeo</b>	24d. LOCATION (City, town, or county) (State) <b>St. Charles, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>9-9-49</b>	REGISTRAR'S SIGNATURE <b>Francis Hauwala</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>St. J. Ballmeyer &amp; Sons Co</b>	ADDRESS <b>800 N. 2nd-St. Charles, Mo.</b>
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RECEIVED SEP 10 1949  
District Health Officer No. 9,  
District File Number.....

**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 4189

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Joseph F Landolt.  
.....

Licensed Embalmer No. 4189

P. O. Address St. Charles

**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.