

FILED OCT 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32199

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2327

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Bonhomme		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Bonhomme	
c. LENGTH OF STAY (in this place) 70		d. STREET ADDRESS (If rural, give location) Oak St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Oak St.			

3. NAME OF DECEASED (Type or Print)	a. (First) August	b. (Middle) Henry	c. (Last) Karl	4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 18, 18'80	9. AGE (In years last birthday) 70	# UNDER 1 YEAR Months	# UNDER 1 MIN. Hours	# UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Own farm	11. BIRTHPLACE (State or foreign country) St. Louis County, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Casper Karl	13b. MOTHER'S MAIDEN NAME Wilhelmina Neuberg	14. NAME OF HUSBAND OR WIFE Alma (Wiehage) Karl
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Alma Karl, Glencoe, Mo, R#1	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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 day 18 mos. 2865
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Osteoparasi DUE TO (c) Malnutrition		
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 2865	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb 4, 1950**, to **Sept 27, 1950**, that I last saw the deceased alive on **Sept 27, 1950**, and that death occurred at **4:53 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Herbert F. Scott M.D. (Degree or title)	23b. ADDRESS Ballwin Mo.	23c. DATE SIGNED Sept 29-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/30/50	24c. NAME OF CEMETERY OR CREMATORY St. John's Ev. Cem.	24d. LOCATION (City, town, or county) (State) Manchester, Mo.
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DATE REC'D BY LOCAL REG. 9-29-50	REGISTRAR'S SIGNATURE Herbert F. Scott M.D.	FUNERAL DIRECTOR'S SIGNATURE Shrader Fun'l Home, Ballwin, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....
Signed *Geo. Schreiber*

Licensed Embalmer No. *3066*

P. O. Address *Baldwin, 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.