

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33099
STATE FILE NUMBER

FILED SEP 16 1957

Registration District No. 310 Primary Registration District No. 6051 Registrar's No. 215

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural - St. Charles Twp		c. CITY OR TOWN Rural - St. Charles Twp	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION R.R #3		d. STREET ADDRESS (If outside, give location) R.R #3	
3. NAME OF DECEASED (Type or print) First August Middle C Last Halbruegge		4. DATE OF DEATH Month Sept. Day 6 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (City and state or country) St. Charles
13a. FATHER'S NAME Ernst Halbruegge		13b. MOTHER'S MAIDEN NAME Carolyn	14. NAME OF HUSBAND OR WIFE Rebecca Schweikher
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 Address Mo. Mr. Hobart Halbruegge, Boschertown,
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) Prostatitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200			INTERVAL BETWEEN ONSET AND DEATH 5 years 20 yrs
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1956 to Sept 1957 and last saw her alive on Sept 6, 1957 Death occurred at 12:50 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) William H Poppemeier MD		22b. ADDRESS St Charles, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 9, 1957	
23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		23d. LOCATION (City, town, or county) (State) St. Charles County, Mo.	
24. FUNERAL DIRECTOR ADDRESS W.C. Dellmeyer & Son, St. Charles, Mo.		25. DATE RECD. BY LOCAL REG. Sept. 9-57	
		26. REGISTRAR'S SIGNATURE Marceena Wilson	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *W E Morris*

Licensed Embalmer No. *3360*
P. O. Address *St Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.