

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

122214
State File No. _____

Registration District No. 756 Primary Registration District No. 4454 Registrar's No. _____

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town Postage
(c) Name of hospital or institution:
West Alton, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 16 days
years, months or days

3. (a) PRINT FULL NAME Infant James Stahlschmidt
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 24 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 0 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace West Alton, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Robert Joseph Stahlschmidt
13. Birthplace West Alton, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Frances Agnes Dyster Miller
15. Birthplace West Alton, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robert J. Stahlschmidt
(b) Address West Alton, Mo.

17. (a) Burial (b) Date thereof March 11 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Immaculate Conception Com.

18. (a) Signature of funeral director H.C. Kallmeyer & Sons
(b) Address 800 N. Second, St. Charles, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Charles
(c) City or town West Alton
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 10
year 1940 hour 5 minute 30 A. M.
21. I hereby certify that I attended the deceased from Feb. 24/40
to March 9, 1940
that I last saw him alive on March 9, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital debility
Due to Premature Birth (twins) at 8 months.
Due to _____
Other conditions (Includes pregnancy within 3 months of death) 12 1/4
Major findings: Of operations _____
Of autopsy _____

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

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?

23. Signature C.A. Barnard M.D. (M. D. or other) _____
Address Postage Box 100 Date signed 4/4/40

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.