

RECORDED AUG 16 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

25492
Do not use this space.

1. PLACE OF DEATH

(a) County JEFFERSON Registration District No. 421
(b) Township JEFFERSON Primary Registration District No. 4249 Registered No. 68
(c) City FESTUS (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

EMMA SEWALD
(a) Residence, No. FESTUS, MO. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOW
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF MICHEL SEWALD
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-31-1846
7. AGE YEARS 93 MONTHS 6 DAYS 10 IF LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Baden Germany
13. NAME Mike Bieser
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Baden Germany
15. MAIDEN NAME Mary M. Steinley
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Baden Germany
17. INFORMANT (ADDRESS) Steinley and Festus, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE French Village DATE 7-12-40
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Frank and Co. Festus, Mo.
20. FILED 7-15-40 J. E. Rutledge Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-10-40
22. I HEREBY CERTIFY That I attended deceased from June 19, 1940 to July 10, 1940
last saw him alive on July 9, 1940 Death is said to have occurred on the date stated above, at 10:00 a.m.
The principal cause of death and related causes of importance were as follows:

Terminal Bronchial Pneumonia
Date of onset July 10
Other contributory causes of importance: Fracture of left hip with severe osteomyelitis, leg hemorrhage in buttocks and bedsores

Name of operation _____ Date of _____
What test confirmed diagnosis? Clinical Was there an autopsy? No
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) J. E. Rutledge M. D.
(Address) 390 Duport City MO

Every item of information should be carefully submitted. Cause of DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important.

X14028

1998
94

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 _____

Elena Province

Licensed Embalmer No. _____

3403

P. O. Address _____

Festus, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25-492**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. **421**

Primary Registration District No. **4249**

Registrar's No. **68**

R
of Crystal City
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
 (a) County Jefferson
 (b) City or town Crystal City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... (Specify whether
 In this community..... (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Emma Sewald
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

8. AGE:	Years	Months	Days	If less than one day
	<u>93</u>	<u>6</u>	<u>10</u>	

9. Birthplace..... (City, town, or county) (State or foreign country)
 10. Usual occupation.....
 11. Industry or business.....

MOTHER FATHER
 12. Name.....
 13. Birthplace..... (City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
 (b) Address.....
 17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)
 (c) Place: burial or cremation.....
 18. (a) Signature of funeral director.....
 (b) Address.....
 19. (a) (Date received local registrar)..... (b) (Registrar's signature).....

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 7 day 10 year 1940 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; (that) last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.
 Immediate cause of death: terminal bronchial pneumonia
 Due to.....
 Due to.....
 Other conditions (Include agency within 3 months of death): Fracture of left hip with severe contusions
 Major findings: Of operations.....
 Of autopsy.....

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) accident
 (b) Date of occurrence July 19-1940
 (c) Where did injury occur? Father Jefferson Mo (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? at home
 While at work? (Specify type of place) (e) Means of injury fall

23. Signature J. Hammer (M. D. or other) MD
 Address Crystal City Mo Date signed 7/14/40

SUPPLEMENTAL

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25-492

Registration District No. 421

Primary Registration District No. 4249

Registrar's No. _____

1. PLACE OF DEATH

(a) County Jefferson
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Emma Sewald

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 93 Months 6 Days 10 If less than one year hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (City, town, or county) (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

20. DATE OF DEATH Month 7 day 10 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Broncho Pneumonia Duration _____

Due to _____
Due to _____

Other conditions Fracture of left hip with severe contusions

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence about June 19/40

(c) Where did injury occur? at home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home

While at work? No (Specify type of place) (e) Means of injury fall

23. Signature _____ (Date signed) _____

Address _____ Date signed 7/19/40

SUPPLEMENTARY

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

vlgq

HOWENA MOORE

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