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FEB 18 1947

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **4069**

Registration District No. **757**

Primary Registration District No. **3036**

Registrar's No. **2**

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1021 S 4th Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles

(c) City or town St. Charles
(If outside city or town limits, write "RURAL")

(d) Street No. 1021 S 4th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME MRS. META DICK BERNI

3. (b) If veteran, name war _____

3. (c) Social Security No. now

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 3rd
year 1946 hour _____ minute _____ M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Henry Dickbern

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: August 21st 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 5, 1940, to Jan 3, 1941;
that I last saw her alive on Jan 3, 1941;
and that death occurred on the date and hour stated above.

8. AGE: Years 62 Months 4 Days 12
If less than one day hr. _____ min. _____

Immediate cause of death: Carcinoma Gall Bladder

Duration: ?

9. Birthplace St. Charles Mo.
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business _____

Major findings: Carcinoma Gall Bladder with Gall Stones

Of operations _____

Of autopsy _____

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

MOTHER FATHER { 12. Name Henry Leuchan

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

14. Maiden name Sophia Mende

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

16. (a) Informant Albert Dickbern

(b) Address St. Charles Mo

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof Jan 6, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(e) Means of injury _____
(Specify type of place)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director W. H. ...

(b) Address 376 N. 6th St - St. Charles Mo

23. Signature J. J. Jenkins (M. D. or other) D

Address St. Charles Mo Date signed 1-7-41

19. (a) 1-4-46 (b) Clarence E. Hessler
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Arthur C. Bane

Licensed Embalmer No.

3145

P. O. Address

St Charles 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.