

Mr. Newbeiser 7979  
State File No. \_\_\_\_\_

ED MAR 19 1941

Registration District No. 257

Primary Registration District No. 3036 A.M.

Registrar's No. 27

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: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Cottonville (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. St. Charles Rock Rd.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME EMMA C. POSEGATE

3. (b) If veteran, name war CIVIL-WAR-WIDOW 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Francis Marion 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased Feb. 29 1852  
(Month) (Day) (Year)

8. AGE: Years 88 Months 11 Days 11 If less than one day hr. min.

9. Birthplace Orford N. H.  
(City, town, or county) (State or foreign country)

10. Usual occupation Household

11. Industry or business \_\_\_\_\_

12. Name Indigenous

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

14. Maiden name Indigenous

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

16. (a) Informant Mother Williams

(b) Address Cottonville, Mo.

17. (a) Cremation (b) Date thereof 2-10-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem.

18. (e) Signature of funeral director Wm. Overland  
(f) Address 2504 Woodson Overland, Mo.

19. (a) 2-10-41 (b) Colver B. Moore  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9  
year 1941 hour 30 minute 11 A.M.

21. I hereby certify that I attended the deceased from 2/2, 1941, to 2/9, 1941

that I last saw her alive on 2/8, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia

Due to Surgical empyema 5 days

Due to gout bladder disease 20 years

Other conditions fracture of hip 10 days  
(Include pregnancy within 3 months of death)

Major findings: Of operations fracture of hip  
Of autopsy not performed

Duration
3 days
5 days
20 years
10 days

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? at home

(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature B. S. Newbeiser (M. D. or other) Dr. D.  
Address St. Charles, Mo. Date signed 2/10/41

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

93  
9  
2

MOTHER FATHER

195 No.  
99

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, fact should be so stated above.**

Registration District No. 757

Primary Registration District No. 3036

Registrar's No. \_\_\_\_\_

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:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emma C Posegate  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Feb day 9  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

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

Immediate cause of death hypostatic pneumonia

8. AGE: Years Months Days If less than one day  
88 11 11 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Duration 1960  
Due to Bladder disease

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

Other conditions fracture of rib  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_

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 1/25/41

(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? home

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury fall

23. Signature B. L. Henderson (M. D. or other) MD

Address St Charles, Mo Date signed 7/31/41

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

SUPPLEMENTAL

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**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, fact should be so stated above.**