

Registration District No. 310

Primary Registration District No. 3058

State File No. \_\_\_\_\_

Registrar's No. 21

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's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Day (Specify whether

In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Herman Bull

3. (b) If veteran, name war None 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Caroline Weber 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased September 17, 1871  
 (Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired

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

12. Name Frederich Bull

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

14. Maiden name Not Known

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

16. (a) Informant Amy Bull

(b) Address ST. CHARLES, MO.

17. (a) Burial (b) Date thereof Jan. 31, 1943  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Cemetery

18. (a) Signature of funeral director Hackmann-Bauer

(b) Address 326 N. 6th St. St. Charles MO

19. (a) 1-30-43 (b) Clarence G. Ulesker  
 (Date received local registrar) (Registrar's signature)

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. 427 N. Third Street  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29th  
 year 1943 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from Dec. 22 1942 to Jan. 29 1943  
 that I last saw him alive on Jan. 28 1943  
 and that death occurred on the date and hour stated above.

Immediate cause of death Ursemia Duration 2 days

Due to Pougey's Heart Disease 3 days

Due to Cardiac Decompensation  
Valvular Heart Disease ?

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

PHYSICIAN

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

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 1-30-43

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

MOTHER FATHER

1954 MAR 3 8 AM

**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.....

*3155*

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3263  
Registrar's No. 21

Registration District No. 310 Primary Registration District No. 3058

1. PLACE OF DEATH:  
(a) County St Charles  
(b) City or town St Charles  
(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 Heerman Bull  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 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 Sept 17 (Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Memia  
from heart disease  
Due to congestive heart disease cardiac decompensation  
Due to valvular heart disease  
Duration \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
13212

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)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 3-24-43

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

MOTHER FATHER

SUPPLEMENTARY

[The page contains extremely faint and illegible text, likely a scan of a document with very low contrast or significant fading. The text is arranged in multiple lines and columns, but no specific words or phrases can be discerned.]