

FILED APR 20 1944

Registration District No. ~~27~~

Primary Registration District No. ~~4454~~ 6.05.01

State File No. 15926

Registrar's No. 3

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town Postage  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Postage De Sioux, Mo.  
(If not in hospital or institution, write street number of location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Lifetime (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles  
(c) City or town Postage 92  
(If outside city or town limits, write "RURAL")  
(d) Street No. Russell 1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 1

3. (a) PRINT FULL NAME

Frank Duwall

3. (b) If veteran, name war No

3. (c) Social Security No. None

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

6. (b) Name of husband or wife Elizabeth Baderfeld 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased July 27 1860  
(Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Postage De Sioux, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Truck Gardner

12. Name John T. Duwall

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

14. Maiden name Antoinette La. Siet

15. Birthplace Postage De Sioux, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Mary Duwall

(b) Address Postage De Sioux, Mo.

17. (a) Burial (b) Date thereof March 10, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francis Lem. Postage De Sioux, Mo.

18. (a) Signature of funeral director H. C. Dalrymple & Sons

(b) Address 801 St. Charles, St. Charles, Mo.

19. (a) Mar. 10 1944 Rose Bargard  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4  
year 1944 hour 11 minute 15 A. M.

21. I hereby certify that I attended the deceased from March 1944  
1944 to March 4, 1944  
that I last saw him alive on March 3, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 days

Due to Atherosclerosis & Hypertension 12 years

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

Major findings: JZ  
.. 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) \_\_\_\_\_  
(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 C. A. Barnard (M. D. or other) 0  
Address Postage De Sioux Date signed 3/7/44

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4 - 20 - 44

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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 John B. Dallmeyer

Licensed Embalmer No. 2451

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.**

B  
3  
96930

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. May  
3

Registration District No. 309

Primary Registration District No. 44509 4454

Registrar's No. 3

1. PLACE OF DEATH:

(a) County H Charles  
(b) City or town Portage Wood, Mo  
(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 Frank Duwall  
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 July 27 1915  
(Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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) C. O. Barnard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May in year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I included the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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) \_\_\_\_\_

(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

YMAA

15626