

FILED MAR 20 1945  
Registration District No. 310

Primary Registration District No. 3058

1. PLACE OF DEATH: St Charles  
 (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:  
518 N. Fifth Street  
 (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 Missouri (b) County St. Charles  
 (c) City or town St. Charles  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 518 N. Fifth Street  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Sophia Poese  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Herman Poese  
 6. (c) Age of husband or wife if alive 83 years  
 7. Birth date of deceased April 1, 1862  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	82	10	9	hr. _____ min.

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

10. Usual occupation Housewife

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

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

16. (a) Informant Margaret Poese  
 (b) Address St. Charles, Mo

17. (a) Burial (b) Date thereof Feb. 13, 1945  
 (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (e) Signature of funeral director Haechmann - Bauer  
 (b) Address 326 N. 6th St. St. Charles Mo

19. (a) Feb 12, 1945 (b) Lorant G. Paule  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 10  
 year 1945 hour 1 minute 35 P. M.

21. I hereby certify that I attended the deceased from Sept 8  
 1942 to Feb 10 1945;  
 that I last saw her alive on Feb 10 1945;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma ascending colon Duration 6 mo

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

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

Other conditions 462  
 (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 V. O. Schumler (M. D. or other) MD  
 Address St. Charles, Mo Date signed 2/12/45

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

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed

3-19-45

MAR 23 1945

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. Bone*

Licensed Embalmer No.

2155

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.