No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24882

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1891

1. PLACE OF DEATH:

(a) County St Louis 317

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

(c) Name of hospital or institution: 2808 Endicott 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 8 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis 96

(c) City or town Overland 12
(If outside city or town limits, write "RURAL")

(d) Street No. 2808 Endicott 1
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Pauline Agler

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female 1

5. Color or race white

6. (a) Single, widowed, married, divorced widowed 1

6. (b) Name of husband or wife Charles Agler

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

7. Birth date of deceased Aug 8th 1868
(Month) (Day) (Year)

8. AGE: Years 76 | Months 11 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Troy, Ills., 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business At Home

FATHER
12. Name Gottleib Schultz
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Henrietta Wille
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Viserjaine
(b) Address 2160 Rosebud - St. Louis Mo

17. (a) removal (b) Date thereof 7/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Collinsville Ills.

18. (a) Signature of funeral director Geo M. Schuseppel
(b) Address Collinsville, Ills.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26th
year 1945 hour 11 minute 42 PM M.

21. I hereby certify that I attended the deceased from July 11, 1945, to July 11, 1945, that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cornery Occlusion	1 day
Due to: Arteriosclerosis	
Due to: 94a	
Other conditions: Senile — (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? —
(Specify type of place)

While at work? — (e) Means of injury _____

23. Signature Roy A. Walther 0 (M. D. or other) —

Address 2438 Woodson Rd. Overland, Mo. Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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 Geo M. Alnoeppel

Licensed Embalmer No. 1598

P. O. Address Collinsville, Ills.,

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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 377 Primary Registration District No. 6076 Registrar's No. 18918

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Overland
(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 Pauline Agler

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 8 (Day) 1866 (Year)

8. AGE: Years 76 Months 4 Days 18 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) E. C. McGovern (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 26 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-24882