

No. 2
1-5-43
5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. 34455
Registrar's No. 149

Registration District No. 310 Primary Registration District No. 3058

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

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:
American Car & Foundry Co shop 3
(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)

3. (a) PRINT FULL NAME Carl Ernst Bulthaupt
3. (b) If veteran, name war World War I 3. (c) Social Security No. 498-10-8599

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 20, 1891
(Month) (Day) (Year)

8. AGE: Years 54 Months _____ Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Inside Finisher

11. Industry or business American Car & Foundry Co

12. Name Henry Bulthaupt

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

14. Maiden name Clara Marie Meyer

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

16. (a) Informant Fred Bulthaupt

(b) Address 824 N. 3rd-St. Charles, Mo.

17. (a) burial (b) Date thereof Oct 14-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lutheran Cem-St. Charles

18. (a) Signature of funeral director H.C. Dallmeyer & Son

(b) Address 800 N. 2nd-St. Charles, Mo.

19. (a) 10/14/45 (b) Ernest E. Paule
(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. 824 North 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 October day 12
year 1945 hour 8:10 minute _____ A M

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

Immediate cause of death Cerebral Hemorrhage
(Jury's verdict)

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy none

Duration _____
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 130

(b) Date of occurrence Oct 12, 1945

(c) Where did injury occur? ST. Charles, St. Charles Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In industrial

While at work at plant means of injury _____

23. Signature Mary Murphy (A.D. or other) _____
Address Wentzville Mo Date signed Oct 12-45

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed _____

11-14-45

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 _____

Philip A. Miceli

Registered Apprentice No. *388*

working under my personal supervision.

Signed *John E. Dellmeyer*

Licensed Embalmer No. *2951*

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.

Registration District No. 310

Primary Registration District No. 3058

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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Carl E. Bulthaupt

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 S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Sept 20 (Month) (Day) (Year)

8. AGE: Years 54 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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)

(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 Oct day _____ year 1958 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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 a Fall

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 Fall

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

34455