

No. 2
12-45
17-39
K47070

FILED FEB 6 1948

State File No.

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 25

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 Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 hours
(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. 1825 North Fourth
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME Alma Margaret Regot

3. (b) If veteran, name war NIL

3. (c) Social Security No. 492-01-8735

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Chauncey Regot

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased March 21 1904
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
43	9	25	hr. min.

9. Birthplace Valley Park-St. Louis Co., Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Arthur Fairchild

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

14. Maiden name Mary Haines

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

16. (a) Informant Chauncey Regot

(b) Address 1825 N. 4th-St. Charles, Mo.

17. (a) burial (b) Date thereof Jan 19-1948
(Burial, cremation, or removed) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery St. Charles, Missouri

18. (a) Signature of funeral director: H.O. Dalmeyer & Sons

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

19. (a) 1-31-48 (b) Fannie Hamilton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 16
year 1948 hour 5:10 minute P.M.

21. I hereby certify that ~~XXXXXXXXXXXX~~ held inquest Jan. 17 1948
19...., to 19....;

that I last saw h. alive on 19.... and that death occurred on the date and hour stated above.

Immediate cause of death:

rifle shot wound
in head
self inflicted

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) suicide

(b) Date of occurrence Jan. 16, 1948

(c) Where did injury occur? St. Charles St. C. Co. MO.
(City or town) (County) (State)

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

While at work? no (Specify type of place)

(e) Means of injury bullet wound

23. Signature Marie M. ...
Address ... Date signed 1-17-48

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

8/5/48

Date of

Death

Death Officer No.

RECEIVED

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.....

Herbert C. Dallmeyer

Registered Apprentice No. *429*

working under my personal supervision.

Signed.....

Joseph I. Landoer

Licensed Embalmer No. *4189*

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 _____ years, months or days)
3. (a) PRINT FULL NAME Alma M. Reges
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 2 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 2 (Month) (Day) (Year)

8. AGE: Years 43 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 _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-31-48 (b) Fannie Hamilton (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 1948 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 _____
Due to _____
Due to _____
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 _____
Signature _____ (M. D. or other)
Date signed _____

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

SUPPLEMENTARY

S-2143