

FILED MAY 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16978

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 6051 Registrar's No. 104

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Charles County Home</u>		d. STREET ADDRESS (If rural, give location) <u>St. Charles County Home-18yrs</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>John</u>	b. (Middle) <u>-----</u>	c. (Last) <u>Edler</u>	(Month) <u>May</u>	(Day) <u>15</u>	(Year) <u>1949</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>??? 1870</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 12 HRS. Hours	IF UNDER 12 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>St. Charles County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown-probably no</u>	16. SOCIAL SECURITY NO. <u>NIL</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Wm Rommelman, Supt., St. Charles, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broken compensation</u>		<u>1 yr 2 mo</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Gen Arterio Sclerosis</u> DUE TO (c) _____		<u>10 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Extensive Ulceration of leg 20 yrs</u>		<u>4500</u>	

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) - (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from May 14<sup>th</sup>, 1949, to May 15<sup>th</sup>, 1949 that I last saw the deceased alive on May 14<sup>th</sup>, 1949 and that death occurred at 5:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>A. P. Erich Schulz M.D.</u>	23b. ADDRESS <u>St. Charles, Mo.</u>	23c. DATE SIGNED <u>5/16/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>May 16-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Peter Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Charles, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>5/17/49</u>	REGISTRAR'S SIGNATURE <u>Rennie H. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D. Ballmeier &amp; Sons Co. 800 N. 2nd-St. Charles, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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Date Filed \_\_\_\_\_  
District File Number MAY 25 1949  
City Health Officer No. 9

**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 \_\_\_\_\_

*No Embalming*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.