

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

305 State File No. 32742  
214 Registrar's No.

FILED OCT 13 1953

BIRTH NO. REG. DIST. NO. 306 PRIMARY REG. DIST. NO. 6048

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Charles</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>O'Fallon</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>St. Mary's Institute</b>	

3. NAME OF DECEASED (Type or Print) <b>Sr. M. Boniface</b>	a. (First)	b. (Middle)	c. (Last) <b>Felderhoff</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>October 2, 1953</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>April 15, 1879</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Heisingen, Essen, Preus.</b>		12. CITIZENRY OF WHAT COUNTRY? <b>U. S. A.</b>

13a. FATHER'S NAME <b>Joseph H. Felderhoff</b>	13b. MOTHER'S MAIDEN NAME <b>Gertrude Brand</b>	14. NAME OF HUSBAND OR WIFE
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>S. Mary Alicia, L.P.P.S.</b>	ADDRESS <b>O'Fallon, Mo.</b>
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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, asthenia, 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) <b>Gen Carcinomatous</b>		<b>3 mo.</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Ca. of sigmoid</b>		<b>3 mo -</b>
DUE TO (c) <b>Congestive H. Failure</b>		<b>1 yr</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Gen arteriosclerosis</b>		<b>1 yr</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>153X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	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 **9-5-53** to **10-2-53**, that I last saw the deceased alive on **10-7-53**, and that death occurred at **2 AM**, from the causes and on the date stated above.

23a. SIGNATURE <b>R. J. Kunkle M.D.</b>	(Degree or title)	23b. ADDRESS <b>St. Charles, Mo.</b>	23c. DATE SIGNED <b>OCT 3 1953</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Oct. 5, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Convent Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>O'Fallon, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Oct 3 1953</b>	REGISTRAR'S SIGNATURE <b>Hannie Brunstetter</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Dallman &amp; Son</b>	ADDRESS <b>St. Charles, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Frank R. Amalenc*

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

*4832*

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

*St. Charles*

**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.