

FILED NOV 8 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35015

State File No.
Registrar's No. 219

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 6051

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before adjustment) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Charles</u>)		c. CITY OR TOWN <u>O'Fallon</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>2 Yr.</u>		e. STREET ADDRESS (If rural, give location) <u>317 E. 4th St.</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Evangelical Emmaus Home</u>			

3. NAME OF DECEASED (Type or Print) <u>FAYE</u>	a. (First)	b. (Middle)	c. (Last) <u>DANIELS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>October 31, 1954</u>
---	------------	-------------	--------------------------	---

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>April 14, 1911</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 1 HRS. Min.
----------------------	-------------------------------	---	--	---	------------------------	----------------------	------------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
--	---	--	---

13a. FATHER'S NAME <u>Henry M. Daniels</u>	13b. MOTHER'S MAIDEN NAME <u>Nellie L. Kampmeyer</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Theophil Stoerker</u>	ADDRESS <u>St. Charles, Mo.</u>
--	-------------------------------------	--	---------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gastro-Intestinal hemorrhage</u>		<u>1 day</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Duodenal ulcer</u> DUE TO (c)		<u>unknown</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Schizophrenia</u>		<u>3 wks</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from Oct 26, 1954, to Oct 31, 1954, that I last saw the deceased alive on Oct 26, 1954, and that death occurred at 8:15 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>William H. Poggemeier MD</u>	23b. ADDRESS <u>200 Clay St Charles, Mo</u>	23c. DATE SIGNED <u>Nov 1, 1954</u>
--	---	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Nov. 1, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Cemet.</u>	24d. LOCATION (City, town, or county) (State) <u>O'Fallon, Illinois</u>
--	-------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>Nov 1 1954</u>	REGISTRAR'S SIGNATURE <u>Hannie Hamlett</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wallshagen-Meyer</u>	ADDRESS <u>O'Fallon, Ill.</u>
--	---	--	-------------------------------

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

920

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.....
Signature of Student Embalmer

Signed.....
Francis M. Bello

Licensed Embalmer No. *4372*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.