

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

26696

SEP 27 1927

1. PLACE OF DEATH

County Cape Girardeau

Registration District No. 125

File No. 931

Township 16

Primary Registration District No. 3009

Registered No. _____

City _____ (No. _____) _____ St. _____ Ward _____

2. FULL NAME

Glen R. C. Hellwege

(a) Residence. No. 1717 West Broadway St. Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 27-1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
7 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Cape Girardeau Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Martin Hellwege

11. BIRTHPLACE OF FATHER (CITY OR TOWN) France
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Maria Sumner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Burlington
(STATE OR COUNTRY) Mo

14. INFORMANT Mr. Martin Hellwege
(Address) 1717 Broadway

15. FILED 9-10-27 W. O. Kaeuffer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 9 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927, to Sept 9, 1927, that I last saw him alive on Sept 9, 1927, and that death occurred, on the date stated above, at 7:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Colitis

CONTRIBUTORY (SECONDARY)

1136

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH. no DATE OF _____

20. WAS THERE AN AUTOPSY. no

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. O. Schaefer, M. D.

(Address) Cape Girardeau Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairmont Cem DATE OF BURIAL 9-10 1927

20. UNDERTAKER Al Bunkoff ADDRESS Cape Gir

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Cause of death should be stated EXACTLY. Exact statement of OCCUPATION is very important.

