

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

Do not use this space.

30018

**1. PLACE OF DEATH**

County Franklin  
Township Lyon  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 300  
Primary Registration District No. 547

File No. \_\_\_\_\_  
Registered No. 20  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Norman Waekenhorst

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)  
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 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 (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-13-27

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 6 hrs. or 1 min.

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Franklin Co Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Christopher J Waekenhorst

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

12. MAIDEN NAME OF MOTHER Caroline J. Waekenhorst

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

14. INFORMANT C. J. Waekenhorst  
(Address) New Haven Mo

15. FILED 10/16-1927 J. H. Matthews  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1927, to Oct 14, 1927, that I last saw him alive on Oct 13, 1927, and that death occurred, on the date stated above, at 1 a m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Subarachnoid Hemorrhage

1608  
1609/6113

(duration) yrs. mos. ds. Birth Trauma

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

**WHAT TEST CONFIRMED DIAGNOSIS**

(Signed) Joseph W. Mills, M. D.

, 19 (Address) New Haven 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**

**DATE OF BURIAL**

Boeffel Lutheran Seminary

10-14 1927

**20. UNDERTAKER**

**ADDRESS**

None

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD

