WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

29896

1. PLACE OF DEATH
County Jackson X — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1992 — Registered No. 3822
City K. C. Mo (No. Wesley Hospital St. Ward)

2. FULL NAME Dr. Aug C. Wunnicke
(a) Residence, No. 2327 Troost Ave St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 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 (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Sophia Wunnicke
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan-7-1867
7. AGE: YEARS 66 — MONTHS 8 — DAYS 19 — If LESS than 1 day, ....hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Physician
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois

FATHER
13. NAME: August Wunnicke
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

MOTHER
15. MAIDEN NAME: Adelaide
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

17. INFORMANT (ADDRESS): Mrs. Sophia Wunnicke 2327 Troost, ave.
18. BURIAL, CREMATION, OR REMOVAL PLACE: Mt. Moriah DATE: Sept. 28, 1933
19. UNDERTAKER (ADDRESS): Mrs. C. L. Foster 918 Brooklyn ave.
20. FILED: 9-27, 1933 M. M. Crowe asst Registrar.

## 4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Sept-26-1933
22. I HEREBY CERTIFY, That I attended deceased from May, 1933, to Sept. 26, 1933
I last saw him alive on Sept. 26, 1933. Death is said to have occurred on the date stated above, at 10:20 a.m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| 463 | |
| Uraemia | |
| 1320 | |
| 1238 | |

Other contributory causes of importance:
Pelvic Abscess
Carcinoma of Rectum
Colostomy

Name of operation: Excision of Rectum Date of Sept. 26, 1933
What test confirmed diagnosis? Autopsy Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) P. W. Johnstone, M. D.
(Address) 633 Lathrop Bldg.