

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

32063
 Do not use this space.

OCT 12 1939

1. PLACE OF DEATH
 (a) County Cape Girardeau Registration District No. 25
 (b) Township Cape Girardeau Primary Registration District No. 309 Registered No. 303
 (c) City Cape Girardeau (d) Street No. St. Francis Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Unnamed Baby Wallenmeyer
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 1, 1939</u>		
7. AGE	YEARS	MONTHS
	<u>0</u>	<u>0</u>
	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>0</u>	<u>0</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
9. Industry or business in which work was done, as 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) <u>Cape Girardeau Mo.</u>		
13. NAME <u>Kenneth A. Wallenmeyer</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Jamestown Mo.</u>		
15. MAIDEN NAME <u>Mississ Penzel</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Jackson Mo.</u>		
17. INFORMANT <u>Kenneth A. Wallenmeyer</u> (ADDRESS) <u>New Madrid Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Russell Heights</u> DATE <u>Sept 2, 1939</u>		
19. FUNERAL DIRECTOR (NAME) <u>Macke-Wilson State</u> (ADDRESS) <u>Jackson Mo.</u>		
20. FILED <u>9-1-39</u> <u>J. M. Thompson</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 1, 1939

22. I HEREBY CERTIFY, THAT I attended deceased from Sept 1, 1939 to Sept 1, 1939
 I last saw him alive on Sept 1, 1939 Death is said to have occurred on the date stated above, at 4:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Congenital heart disease at Birth
 Date of onset at Birth

Other contributory causes of importance:
Pathological fracture of right humerus

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? no

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 hospital
 Nature of injury fracture while passing through birth canal

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify
 (Signed) M. D.
 (Address) Jackson, Mo.

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.

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STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH

MISSISSIPPI DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
STATE OF MISSISSIPPI

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, _____

Glenn Wilson

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. 2828

P. O. Address _____

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32063
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 125-
(b) Township Cape Girardeau Primary Registration District No. 3009 Registered No. 303
(c) City Cape Girardeau (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME unnamed Baby - Wallenmeyer

(a) Residence, No. _____ (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 8

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
— 0 0 0 2 hrs.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as 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) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 11 - 2 - 1939 J. M. Simpson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance: 5

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) Albert M. Estes, M. D.

(Address) Jackson, Mo.

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN S should not be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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