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11-10-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18347

State File No.

Registration District No. 297

Primary Registration District No. 3016

Registrar's No. 52

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Yes
years, months or days 14 Days

3. (a) PRINT FULL NAME LOUISE WALKENHORST

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Therman W. Walkenhorst 6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased May 28 1866
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Worthaven, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Lehrer Hermann
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mary Zimmerman
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Therman Walkenhorst

(b) Address Worthaven, Mo.

17. (a) Buried (b) Date thereof 5/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW HAVEN, BRISTOL TOWNSHIP, ILL.

18. (a) Signature of funeral director H. H. May

(b) Address Worthaven, Mo.

19. (a) May 8-1940 (b) H. H. May
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Worthaven
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19 year 1940 hour 11 minute 55 P. M.

21. I hereby certify that I attended the deceased from April 19 1940 to May 6 1940
that I last saw him alive on May 5 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension
Pneumonia bilateral Duration 6 days

Due to Chronic myocarditis

Due to Fracture of femur
third right femur

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations no operation

Of autopsy no autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence April 19, 1940

(c) Where did injury occur? near home Franklin
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

210 House (Specify type of place)

While at work? no (e) Means of injury fall

23. Signature R. R. Coker (M. D. or other)

Address Washington, Mo. Date signed 5-6-40

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

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, ~~on~~

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

Signed

Carl Hertig

Licensed Embalmer No.

3383

P. O. Address

Yonkers N.Y.

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.