

Registration District No. **305**Primary Registration District No. **5422**Registrar's No. **18**

1. PLACE OF DEATH:

(a) County GASCONADE
 (b) City or town ROSEBUD
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
ROSEBUD
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
 (Specify whether
 In this community 154 YRS.
 years, months or days)

8. (a) PRINT FULL NAME J. HENRY WEHMEYER3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife LOUISE WEHMEYER 6. (c) Age of husband or wife if alive DEAD years
 7. Birth date of deceased JULY 18 1862
 (Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 1 If less than one day hr. min.9. Birthplace ROSEBUD (RURAL) MISSOURI
(City, town, or county) (State or foreign country)10. Usual occupation FARMING

11. Industry or business

MOTHER FATHER
 12. Name HENRY WEHMEYER
 13. Birthplace GERMANY
 (City, town, or county) (State or foreign country)
 14. Maiden name MARIA WINTER
 15. Birthplace GERMANY
 (City, town, or county) (State or foreign country)

16. (a) Informant ERWIN WEHMEYER
(b) Address ROSEBUD, MISSOURI17. (a) BURIAL (b) Date thereof 6-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation LUTHERAN CEMETERY AT ROSEBUD18. (a) Signature of funeral director W. J. Gattenstroeten(b) Address Quensenville, Mo.19. (a) 6-26-40 (b) Walter A. Banner, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GASCONADE
 (c) City or town ROSEBUD
 (If outside city or town limits, write "RURAL")
 (d) Street No. 20
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 19
year 1940 hour 4 minute 10 P.M.21. I hereby certify that I attended the deceased from 7:30 P.M. 24
1940, to June 19 1940
that I last saw him alive on June 19 1940
and that death occurred on the date and hour stated above.Immediate cause of death Coronary ThrombosisDue to Arteriosclerosis 10 yrs.Due to Hypertension 2 yrs.Other conditions Polonephritis, Bilateral 2 mos.
(Include pregnancy within 3 months of death)

Major findings:

Of operations 94%

Of 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)

(b) Date of occurrence

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

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

(Specify type of place) While at work? Means of injury

23. Signature Paul A. Bernal (M. D. or other) MD
Address Quensenville, Mo. Date signed 6-22-40

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, or by.....
Lloyd Ficke....., Registered Apprentice No. *247*
working under my personal supervision.

Signed *W.F. Gattenstrater*
Licensed Embalmer No. *1448*
P. O. Address *Owensville Mo*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21710

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 305-

Primary Registration District No. 2422

Registrar's No. 18

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

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Canaan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

John Henry Wehner

3. (b) If veteran name war.....

3. (c) Social Security No.....

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased.....

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

77

11

1

..... hr. min.

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a).....

(b) Date thereof.....

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 6-30-40
(Date received local registrar)

(b) Paul A. Bannan M.D.
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (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 June day 19 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that I last saw h..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....
Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

Duration
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).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work..... (Specify type of place)
23. Signature Paul A. Bannan (M.D. or other)
Address Levensville Date 7/30

