

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

39068

State File No.

Registration District No. 470

Primary Registration District No. 5633

Registrar's No. 143

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Mount Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 1/4 days
(Specify whether
In this community 15 1/4 days
years, months or days) 3

2. USUAL RESIDENCE OF DECEASED:

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

DEC 11 1940

3. (a) PRINT FULL NAME Henry Soehlig

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 14 (Month) (Day) (Year)

8. AGE: Years 26 Months 3 Days _____ If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name August Soehlig

13. Birthplace Unknown (City, town, or county) Missouri (State or foreign country)

14. Maiden name Ureliia Wedekind

15. Birthplace Unknown (City, town, or county) Missouri (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk

(b) Address Missouri State Sanatorium

17. (a) Removal (b) Date thereof 11-14-40 (Month) (Day) (Year)

(c) Place: burial or cremation Jackson Mo

18. (a) Signature of funeral director Geo B Orr

(b) Address Missouri State Sanatorium

19. (a) 11-13-1940 (Date received local registrar) (b) F.A. HOLMES (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 13th year 1940 hour 12:15 minute 4 M.

21. I hereby certify that I attended the deceased from August 22d 1936 to Nov. 13 1940 that I last saw him alive on Nov. 12 1940 and that death occurred on the date and hour stated above:

Immediate cause of death Pneumonia Duration About Six Year

Tuberculosis

Due to _____

Due to _____

Other conditions 77 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____ (e) Means of injury _____

23. Signature Charles J. McMichael (M.D. or other) _____

Address Mo Vernon Date signed 11/14

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6,

District File Number 1140-2933

Date Filed DEC 5 1940

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

Signed.....

Licensed Embalmer No.....

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.