

Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Anthony's Hospital** **6**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County **Montgomery** **70**

(c) City or town..... **McKittrick** **N. R. 00**
(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.?..... **1** years.

3. (a) PRINT FULL NAME..... **Joseph Walkenbach**

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, **Married**

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

6. (c) Age of husband or wife if alive **64** years

7. Birth date of deceased **March 15 1883**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
57	10	10hr.min.

9. Birthplace..... **Morrilton / Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation..... **Farmer**

11. Industry or business.....

MOTHER FATHER

12. Name..... **William Walkenbach**

13. Birthplace..... **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name..... **Catherine Seibert**

15. Birthplace..... **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Mrs. Katherine Walkenbach**

(b) Address..... **McKittrick, Mo.**

17. (a) **Burial** (b) Date thereof **1/28/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Rhineland, Mo.**

18. (a) Signature of funeral director..... **Albert H. Hopper**

(b) **JAN 27 1941** **700 Washington Ave.**

19. (a) (Date received local registrar).....

(b) **J. W. Seibert** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **25** day **Jan**
year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
....., 19**41** to....., 19**41**,
that I last saw him alive on....., 19**41**,
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Relapsed Pulmonary Colloidal

Due to.....

Due to.....

Other conditions.....
Strains, infection of bladder, kidney,

Major findings: **Advanced carcinoma of bladder, suprapubic, prostate,**

Of autopsy..... **Same**

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..... **5/10**

(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) (e) Means of injury

23. Signature..... **W. J. Seibert** (M. D. or other)

Address..... **729 Missouri Bldg.** Date signed..... **1/27/41**

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

J. S. Sullivan

Licensed Embalmer No. 1122

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, fact should be so stated above.