

FILLED NOV 6 1941
Registration District No. **8**

Primary Registration District No. **201**

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

1. PLACE OF DEATH:
(a) County **Benton**
(b) City or town **Lincoln**
(c) Name of hospital or institution: **Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None**
In this community **7 1/2 yrs (Rural)**

3. (a) PRINT FULL NAME **William Wilshusen**
3. (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 **Adelheid Deluenhal**
6. (c) Age of husband or wife if alive **77** years
7. Birth date of deceased **September 12 1860**

8. AGE:	Years	Months	Days	If less than one day
	81		24	hr. min.

9. Birthplace **Hanover Germany**

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER
12. Name **Claus Wilshusen**
13. Birthplace **Don't Know Germany**
14. Maiden name **Gescha Helmers**
15. Birthplace **Don't Know German**

16. (a) Informant **Emil H. Wilshusen**
(b) Address **Fordville Nebr.**

17. (c) Place: burial or cremation **Mt. Hulda**
(b) Date thereof **Oct. 10 1941**

18. (a) Signature of funeral director **J. B. Calvert**
(b) Address **Lincoln Mo.**

19. (a) **10-10-41**
(b) **Sue Selover**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Benton**
(c) City or town **Lincoln**
(d) Street No. **0**
(e) If foreign born, how long in U. S. A.? **72** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **6**
year **1941** hour **1** minute **A** M.

21. I hereby certify that I attended the deceased from **7-1-41** to **10-6-41**
that I last saw him alive on **10-6-41**
and that death occurred on the date and hour stated above.

Immediate cause of death **of carcinoma of bladder**

Due to
Due to
Other conditions (include pregnancy within 3 months of death) **52 R**

Major findings:
Of operations
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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? **0**
23. Signature **D. Reser** (M. D. or other) **0**
Address **Cole Camp Mo.** Date signed **10-6-41**

RECEIVED

District Health Officer No. 7¹

District File Number 11-41-1780

Date Filed 11-3-41

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.....

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, fact should be so stated above.