

FILLED DEC 6 1941

Registration District No. 770

Primary Registration District No. 6016

Registrar's No. 4

1. PLACE OF DEATH:

(a) County: St. Clair
(b) City or town: TABER Rural
(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: _____ (Specify whether)
In this community: 40 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: St. Clair
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LOUISE WILLEMS

3. (b) If veteran, name war: none 3. (c) Social Security No. none

4. Sex: female 5. Color or race: white 5. (a) Single, widowed, married, divorced: widowed
6. (b) Name of husband or wife: Henry R. Willem 6. (c) Age of husband or wife if alive: 28 - 1860
7. Birth date of deceased: Apr (Month) 28 (Day) 1860 (Year)

8. AGE: Years 81 Months 6 Days 5 If less than one day hr. _____ min. _____

9. Birthplace: St. Louis Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation: House keeping

11. Industry or business _____

MOTHER FATHER { 12. Name: Jacob Kindeer
13. Birthplace: Germany
14. Maiden name: unknown
15. Birthplace: Germany

16. (a) Informant: E B Willem

(b) Address: Appleton City Mo

17. (a) Burial (b) Date thereof: Nov 5 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Appleton City

18. (a) Signature of funeral director: Frank

(b) Address: Appleton City Mo

19. (a) Nov 5 1941 (b) George
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 3 year 1941 hour 4 minute - P.M.

21. I hereby certify that I attended the deceased from Sept 21, 1941 to Nov 3, 1941; that I last saw her alive on Oct 28, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Gastric Carcinoma 2/1/39
Myocardial insufficiency 7/1/31

Due to _____
Other conditions: Chronic nephritis 6/1/40
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations: none performed
Of autopsy: none performed
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) _____ Means of injury: 2

23. Signature: M. O. Bjerke (M. D. or other) P. O.
Address: Rockwell, Mo. Date signed: 11/4/41

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

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RECEIVED

District Health Officer No. 7,

District File Number 12-41-1952

Date Filed 12-3-41

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.

STANDARD CERTIFICATE OF DEATH

State File No. 39278

Registration District No. 270

Primary Registration District No. 6016

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Saber
(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 _____
(years, months or days)

3. (a) PRINT FULL NAME Laurice Wilkins

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 W

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

7. Birth date of deceased Apr. 28 1941
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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) _____ (b) _____
(Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ live on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to carcinoma of the Pylorus of Stomach (Primary seat)
Due to _____

Other conditions _____
(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? _____

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

23. Signature M. E. Bjerke (M. D. or other) P.O.
Address Rockville, Mo. Date signed 11/2/42

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

