

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 23 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32812

Registration District No. 362

Primary Registration District No. 6234

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Warren

(b) City or town Rural Elkhorn Township
(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 Mary Matilda Wiegand

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F.

5. Color or race W.

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

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

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Sept 10 1877
(Month) (Day) (Year)

8. AGE: Years 65 Months 11 Days 20
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 wife

11. Industry or business _____

MOTHER FATHER

12. Name August Pohlman

13. Birthplace St Louis Co MO
(City, town, or county) (State or foreign country)

14. Maiden name Anna Helfman

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

16. (a) Informant's own signature James G. Wiegand

(b) Address Baden St St

17. (a) Burial (b) Date thereof Sept. 4 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salon con Black Mt

18. (a) Signature of funeral director Wright City Mo

(b) Address _____

19. (a) Sept 21 1943 (b) James A. Behrman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Warren 194

(c) City or town Rural Elkhorn Twp
(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 Sept day 1st
year 1943 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 10 1943 to Sept 1 1943
that I last saw alive on Sept 1 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration _____

Due to _____

Due to _____

Other conditions _____
(Includes pregnancy within 9 months of death)

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

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) (e) Means of injury

23. Signature Alvord H. Wiegand (M. D. or other) Dr.

Address Wasson, Mo. Date signed 9/1/43

SEP 24 1943

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 Julius J. Nieburg
Licensed Embalmer No. 3366
P. O. Address Wright City 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.