

FILED JAN 5 1944

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:  
Missouri Methodist Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week  
(Specify whether years, months or days)

In this community 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 1913 Beattie Street  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Rose Gable Wendler

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Charles R. Windler

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

7. Birth date of deceased: April 4 1862  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>8</u>	<u>14</u>	hr. <u>    </u> min. <u>    </u>

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

10. Usual occupation Own Home Work

11. Industry or business     

12. Name Henry Naylor

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

14. Maiden name Unknown

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

16. (a) Informant Carl R. Wendler

(b) Address 1913 Beattie St., St. Joseph, Mo.

17. (a) Burial (b) Date thereof 12/21/1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Falter Meierhoffer

(b) Address 1302 Faron St., St. Joseph, Mo.

19. (a) 12-21-43 (b) Rose Herzog  
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 18th.  
year 1943 hour 3:00 minute P. M.

21. I hereby certify that I attended the deceased from Dec 11, 1943, to Dec 18, 1943  
that I last saw her alive on December 18, 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage into cerebrum

Due to Arteriosclerosis, general

Other conditions Heart Disease, Arteriosclerosis, Bronchopneumonia

Major findings:  
Of operations       
Of autopsy yes

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) (e) Means of injury     

23. Signature R. W. Carl (M. D. or other)       
Address St. Joseph, Mo. Date signed 12-20

Duration 8da

PHYSICIAN     

Underline the cause to which death should be charged statistically.

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

**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..... *Albert R. Harrington* .....

Licensed Embalmer No. 3258 Missouri.....

P. O. Address..... St. Joseph, Missouri.....

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 1298

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(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 Rose Lable Weadler  
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

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

7. Birth date of deceased April 4 1884  
(Month) (Day) (Year)

8. AGE: Years 81 Months 8 Days 1 (less than one day) min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

20. DATE OF DEATH: Month Dec Day 18 year 1944 hour 11 minute 00 M.

21. I hereby certify that I attended the deceased from 1944 to 1944, that I last saw him alive on 1944 and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage into cerebrum Duration 80 hrs.

Due to arteriosclerosis, general

Due to

Other conditions Heart Disease, chronic nephritis, arteriosclerosis (Include pregnancy within 3 months of death)

Major findings: Of operations Bronchopneumonia PHYSICIAN

Of autopsy 930 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 (M. D. or other)  
Address Date signed

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

SUPPLEMENTARY

3-41752