

S. No. -
M-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13996

FILED MAY 15 1944

Registration District No. _____

Primary Registration District No. 3002

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Audrain
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Audrain Hospital
(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 4
(c) City or town infant (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 0

3. (a) PRINT FULL NAME JOHN WILLIAM HILKENMEYER

3. (b) If veteran, name war L 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced L
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
alive _____ years

7. Birth date of deceased March 30 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 4 hr. 30 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Errol F. Hilkenmeyer
13. Birthplace Montgomery, Mo
(City, town, or county) (State or foreign country)
14. Maiden name Margaret M. Mackie
15. Birthplace Montgomery, Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Edith Brondenburg
(b) Address Montgomery City, Mo

17. (a) Burial (b) Date thereof 3/31/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial, Montgomery Mo

18. (a) Signature of funeral director T. B. Hella
(b) Address Hellville Mo

19. (a) 3/31/44 (b) Margaret M. Mackie
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30
year 1944 hour 10:30 minute _____ A. M.

21. I hereby certify that I attended the deceased from March 30 1944 to March 30 1944
that I last saw him alive on March 30 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Constitutional heart disease
Duration _____

Due to Prematurity
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 159
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 J. H. Blund (M. D. or other) _____
Address Willard Mo Date signed 3/31/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

1014

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 5-44-971

Date Filed MAY-1-2-1944

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.....

No Embalming....., Registered Apprentice No.....
working under my personal supervision.

Signed T. B. Kell.....

Licensed Embalmer No. 1588

P. O. Address Nilesville 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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. MayRegistration District No. 10Primary Registration District No. 2002Registrar's No. 46

1. PLACE OF DEATH:

(a) County Andrew
 (b) City or town Wells
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Andrew Hosp
 (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

John W. Helkemeier

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 _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min

9. Birthplace _____ (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 _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Margaret H. Maske
(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 _____ alive on _____, 19____; and that the death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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? _____ (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

13996