

FILED MAY 3 1944
Registration District No. **3017**

Primary Registration District No. **3017**

1. PLACE OF DEATH:
(a) County **COOPER**
(b) City or town **BOONVILLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ST. JOSEPH'S HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 DAYS**
In this community **3 WEEKS**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **COOPER**
(c) City or town **PILOT GROVE (RURAL)**
(If outside city or town limits, write "RURAL")
(d) Street No. **RURAL** (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MRS SOPHIA WIDEL**
(b) If veteran, name war **NONE**
(c) Social Security No. **NONE**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **APRIL** day **10th**
year **1944** hour **7:20** minute _____ P. M.

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **WIDOWED**
(b) Name of husband or wife **JOHN WIDEL**
(c) Age of husband or wife if alive **DECEASED**
7. Birth date of deceased **JULY 2 1866**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 29, 1944** to **April 10, 1944**, that I last saw her alive on **April 10, 1944**, and that death occurred on the date and hour stated above.

8. AGE: Years **77** Months **9** Days **8**
If less than one day _____ hr. _____ min.

Immediate cause of death **Cerebral Hemorrhage**
Duration **14 days**

9. Birthplace **QUINCY ILLINOIS**
(City, town, or county) (State or foreign country)

Due to **Hypertension** years _____

10. Usual occupation **HOUSEWIFE**

Due to _____

11. Industry or business **HOME**

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

12. Name **LOUIS HALLER**

Major findings: Of operations _____

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

Of autopsy _____

14. Maiden name **SOPHIA KUNZWEILER**

Underline the cause to which death should be charged statistically.

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

22. If death was due to external causes, fill in the following:

16. (a) Informant **MRS ALFRED LAMMERS**

(a) Accident, suicide, or homicide (specify) _____

(b) Address **BOONVILLE, MO**

(b) Date of occurrence _____

17. (a) **BURIAL** (b) Date thereof **4/13/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? (City or town) (County) (State)

(c) Place: burial or cremation **MARTINSVILLE, MO.**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director **STEGNER & KOENIG**

(Specify type of place) _____

(b) Address **BOONVILLE, MO.**

While at work? _____ (e) Means of injury _____

19. (a) **APR. 14-44** (b) **Dr. Chas. Swap**
(Date received local registrar) (Registrar's signature)

23. Signature **M. H. Ziegler** (M. D. or other) **M.D.**

Address **Boonville Mo.** Date signed **4-12-44**

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

7
1
2

1089

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

5-2-44

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

James W. Stegner

Licensed Embalmer No.

3780

P. O. Address

Boonville, 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.