

FILED OCT 13 1944

Registration District No. 377

Primary Registration District No. 3071

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Slater  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 228 E Clyde  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no  
(Specify whether  
In this community 28 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline 97  
(c) City or town Slater  
(If outside city or town limits, write "RURAL")  
(d) Street No. 228 E Clyde  
(If rural, give location)  
(e) Citizen of foreign country? ..... (Yes or No)  
If yes, name country .....

3. (a) PRINT FULL NAME Johanna Alvina Berlekamp

3. (b) If veteran, name was ..... 3. (c) Social Security No. ....

4. Sex Female 5. Color or race wh  
6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife. .... 6. (c) Age of husband or wife if alive 7 years  
7. Birth date of deceased Dec. 1863  
(Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 0 If less than one day  
hr. min.

9. Birthplace Dec 4 Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business

MOTHER FATHER { 12. Name August Wicks  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Wickman  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant August Berlekamp  
(b) Address Slater Mo

17. (a) burial (b) Date thereof 9-8-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Slater Mo

18. (a) Signature of funeral director Hell Brothers  
(b) Address Slater Mo

19. (a) Oct 4-1944 (b) Mrs. John Giger  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 6  
year 1944 hour 7 minute ..... M.

21. I hereby certify that I attended the deceased from Sept 15 1944 to Sept 6 1944  
that I last saw him alive on July 15 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 3 yrs  
Due to arteriosclerosis of heart 1 yrs  
Due to cesses, lungs - heart 4 yrs

Other conditions There is no other 6 yrs?  
(Include pregnancy within 3 months of death)

Major findings: Of operations none  
Of autopsy none 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) no  
(b) Date of occurrence .....  
(c) Where did injury occur? no  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
no

While at work? no (Specify type of place) (a) Means of injury

23. Signature H. G. Giger (M. D. or other)  
Address Slater Mo Date signed 9-6-44

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

RECEIVED  
ORDER No. 8  
10-11-47

**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 Sam M Hill  
Licensed Embalmer No. 1292  
P. O. Address Platte 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.**