V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 2884

FILED JAN 16 1945

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 370

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

**1. PLACE OF DEATH:**

(a) County Marion

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

(c) Name of hospital or institution: St Elizabeth
(If not in hospital or institution, write street number or location)

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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Illinois (b) County Pike 999

(c) City or town New Canton 11
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME Robert Wernowsky

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Leta

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

7. Birth date of deceased January (Month) 9 (Day) 1898 (Year)

8. AGE: Years 46 Months 10 Days 10 If less than one day hr. min.

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

10. Usual occupation Tavern Owner

11. Industry or business

FATHER
12. Name Charles Wernowsky
13. Birthplace Germany (City, town, or county) 11 (State or foreign country)

MOTHER
14. Maiden name Emma Winklemann
15. Birthplace Germany (City, town, or county) 11 (State or foreign country)

16. (a) Informant Edna Godfrey

(b) Address New Canton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-44 (Month) (Day) (Year)

(c) Place: burial or cremation Sheppers — New Canton Ill

18. (a) Signature of funeral director Wm H Smith

(b) Address Hannibal Mo

19. (a) 11-22-44 (Date received local registrar) (b) R H Connor (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month November day 19th year 1944 hour 9 A.M. minute M.

21. I hereby certify that I attended the deceased from November 18, 1944, to Nov 19, 1944, that I last saw him alive on Nov 19, 1944 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Angina pectoris | |
| Due to | |
| Due to | |
| Other conditions: Chr myocarditis (Include pregnancy within 3 months of death) | |
| Major findings: Of operations: 9 3d | |
| 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 1001 Broadway Hannibal Mo Date signed 11-22-44

(Licensed Embalmer's Statement on Reverse Side)

## 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 George T. Bond

Licensed Embalmer No. 4373

P. O. Address 602 Broadway Hannibal

**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.**