

FILED MAR 9 1945  
Registration District No. **17**

Primary Registration District No. **4268**

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

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lafayette

(c) City or town Mayview  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

3. (a) PRINT FULL NAME Wilhemine Reuter

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22 year 1945 hour 7 minute A. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Jan. 10 1897  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 22 1945 to Feb. 22 1945; that I last saw him alive on Feb. 22 1945 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>87</u>	<u>1</u>	<u>12</u>	hr. _____ min. _____

Immediate cause of death: Cerebral hemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Karl Zinke

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

14. Maiden name Henriette Chappeler

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

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 \_\_\_\_\_

16. (a) Informant Mrs Albert Schwenck

(b) Address Mayview Mo

17. (a) Burial (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 25-24-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Digginsville Elys Com

18. (a) Signature of funeral director W. Minnerhagen

(b) Address Digginsville Mo

19. (a) Feb-25-1945 (Date received local registra) \_\_\_\_\_ (b) Mrs W. Baker (Registrar's signature)

23. Signature J. O. Bellis, M. D. (M. D. or other) \_\_\_\_\_

Address Mayview Mo Date signed 3/23/45

1157

RECEIVED

District Health Officer No. 8,

District File Number

Date

3-7-45

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

Roy A. Wiegans

Licensed Embalmer No. 2883

P. O. Address

Hiramville 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.