

FILED APR 5 1945

Registration District No. **7/1945**

Primary Registration District No. **5443**

Registrar's No. **7**

1. PLACE OF DEATH:

(a) County **Gasconade**
(b) City or town **Rural - Roark Twp**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **His Residence**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Entire Life**
years, months or days

3. (a) PRINT FULL NAME **ARTHUR CHRISTIAN VOLLERTSEN**

3. (b) If veteran, name war **No**
3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**
6. (b) Name of husband or wife **Rosa**
6. (a) ~~Single~~ **Widowed, married, divorced**
6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **Sept. 4 1881**
(Month) (Day) (Year)

8. AGE: Years **63** Months **6** Days **23**
If less than one day _____ hr. _____ min.

9. Birthplace **Gasconade Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Farming**

MOTHER FATHER { 12. Name **John Vollertsen**
13. Birthplace **unknown Denmark**
(City, town, or county) (State or foreign country)
14. Maiden name **Caroline Groeber**
15. Birthplace **Unknown Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Arthur Vollertsen**
(b) Address **Hermann, Mo. R.F.D.**
17. (a) **Burial** (b) Date thereof **3-30-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Hermann City Cem.**

18. (a) Signature of funeral director **Paul H. Blumner**
(b) Address **Berger Missouri**
19. (a) **march 27/45** (b) **A. H. Hedler**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Gasconade**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **3 1/2 miles S.E. Of Hermann, Mo.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **27th**
year **1945** hour **5** minute **30 a.M.**

21. I hereby certify that I attended the deceased from **March 22nd 1945** to **March 27th 1945**
that I last saw him alive on **March 26** 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Chronic Nephritis

Due to _____

Due to **131b**

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

Major findings: _____
Of operations _____
Of autopsy _____
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 **E. G. Rhodius** (M. D. or other) _____
Address **Hermann Mo** Date signed **3/27/45**

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

126'

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 4-4-45

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 _____

Chas. M. Pope

Licensed Embalmer No. 2552

P. O. Address Hammam, 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.