

FILED APR 10 1945 274

Primary Registration District No. 3052

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Idalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bethnell Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

Douglas Wexneke

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced L
6. (b) Name of husband or wife L 6. (c) Age of husband or wife if alive 4 years
7. Birth date of deceased Mar 28 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 18 hr. _____ min.

9. Birthplace Idalia Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Walter F Wexneke
13. Birthplace Houstonia Mo
(City, town, or county) (State or foreign country)
14. Maiden name Theresa Hauchen
15. Birthplace Houstonia Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Wexneke

(b) Address Houstonia Mo

17. (a) burial (b) Date thereof 3-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Houstonia

18. (a) Signature of funeral director Spethbrook

(b) Address Houstonia Mo

19. (a) 3-29-45 (b) Mrs Anne Beyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis
(c) City or town Houstonia Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 29
year 1945 hour 4 minute P M.

21. I hereby certify that I attended the deceased from 3/29, 1945 to 3/29, 1945
that I last saw him alive on 3/29, 1945
and that death occurred on the date and hour stated above.
Immediate cause of death _____

premature birth Duration 2 Mo

Due to Defected Vision of

Due to Mother - Necessitated

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

Major findings: Of operations _____

Of autopsy 159

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature Dr. Beyer (M. D. or other)

Address Idalia Mo Date signed 3/29/45

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

RECEIVED

District Health Officer No. 8,

Serial File Number

Date Filed

6/7/45

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

H. H. Smiley

Licensed Embalmer No.

3987

P. O. Address

Houstonia

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.