

**FILED JUN 13 1945**  
Registration District No. 200

Primary Registration District No. 6728

Registrar's No. 49

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

1. PLACE OF DEATH:  
(a) County MACON  
(b) City or town ANABEL R. Missouri  
(c) Name of hospital or institution: 1 Chapel  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 5 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County MACON  
(c) City or town ANABEL R. I  
(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 WILLIAM M. WAHL  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 13  
year 1945 hour 1 P minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 13, 1945 to only, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife BERTHA 6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased nov 27 1878  
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage Duration 1 day

8. AGE: Years 66 Months 5 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace GERMANY  
(City, town, or county) (State or foreign country)  
10. Usual occupation FARMER

Major findings: gfu  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name not known  
13. Birthplace GERMANY  
(City, town, or county) (State or foreign country)  
14. Maiden name not known  
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? \_\_\_\_\_

16. (a) Informant MRS BERTHA WAHL  
(b) Address ANABEL MO RI  
17. (a) BURIAL (b) Date thereof MAY 13 1945  
(Burial, cremation, or removal) (Monthly) (Day) (Year)  
(c) Place: burial or cremation CLARENCE OLD CEMETERY  
18. (a) Signature of funeral director William B. Bunker  
(b) Address Clarence  
19. (a) 5/18/45 (b) W. B. Bunker  
(Date occurred local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
23. Signature D. L. Harlan (M. D. or other)  
Address Clarence mo Date signed 5/14/45

RECEIVED

District Health Officer No. 10

District File Number 6-15-949

Date Filed JUN 12 1945

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.....

*E. W. Hawkins*

Licensed Embalmer No. 3498

P. O. Address.....

*Shelbourn 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.