

Registration District No. 4571

Primary Registration District No. 4268

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (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 Henry Wehking

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 Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased July 4 - 1866
(Month) (Day) (Year)

8. AGE: Years 81 Months 11 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired farmer

11. Industry or business _____

12. Name Henry Wehking

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

14. Maiden name Angela Wagoner

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

16. (a) Informant Alfred Stager
(b) Address Mayview, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-45
(Month) (Day) (Year)

(c) Place: burial or cremation Evg. Cemetery, Mayview, Mo.

18. (a) Signature of funeral director Alfred Stager
(b) Address Higginsville, Mo.

19. (a) June 21-1945 (Date received local registrar) (b) Mrs W.S. Baker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17 year 1945 hour 4 minute A M.

21. I hereby certify that I attended the deceased from June 26, 1945 to June 17, 1945
that I last saw him alive on June 17, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis

Due to Chronic arteritis

Due to _____

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

Major findings: Of operations None Of autopsy None

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? _____

(e) Means of injury _____ (Specify type of place) While at work? _____ (M. D. or other)

23. Signature Jo B. Willis (M. D. or other) Address Mayview, Mo. Date signed 6/19/45

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2/10/41

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 Forrest A. Hooper

Licensed Embalmer No. 4358

P. O. Address Higginsville, 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.