

S. No. 2
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
FILED JUL 13 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. 568

Registration District No. 184 Primary Registration District No. 3038

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

1. PLACE OF DEATH:
 (a) County Linn
 (b) City or town Bronckfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: McLennan Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Days (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME JOE B WEHNER
 3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
 7. Birth date of deceased: November 22 1885
 (Month) (Day) (Year)

8. AGE: Years 59 Months 7 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

MOTHER FATHER
 11. Industry or business _____
 12. Name Joe Wehner
 13. Birthplace Crown Point, Indiana
 (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Muller
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant Pete Wehner
 (b) Address New Cambria Mo.

17. (a) Burial (b) Date thereof June 28 45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cemetery
 18. (a) Signature of funeral director H. J. Billeland

(b) Address New Cambria Mo.

19. (a) 6-28-1945 (b) W. W. Cannon
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Macon
 (c) City or town New Cambria (Rural)
 (If outside city or town limits, write "RURAL")
 (d) Street No. five miles south of New Cambria
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25th.
 year 1945 hour 12 minute 40 P.M.
 21. I hereby certify that I attended the deceased from June 24
 1945 to June 25, 1945
 that I last saw him alive on June 25, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Cardiac Dilatation
 Due to Arteriosclerotic Cholesterol of Liver
 Duration 1 day

Other conditions: Loose Ingestion
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy 1242
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?

(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature P. J. Haly (M. D. or other) MD
 Address Bronckfield Date signed 6-27-45

RECEIVED

District Health Officer No. 11,

District File Number.....

Date Filed.....

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. J. Gilliland*

Licensed Embalmer No. *4019*

P. O. Address..... *New Cambria, 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.