

No. 2
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5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30500

State File No. _____
Registrar's No. 89

Registration District No. 116 Primary Registration District No. 3020 5434

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. James Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days (Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME: HENRY F. WALKENHORST
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race W
6. (b) Name of husband or wife Gina Walkenhorst 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased Nov 25 1883
(Month) (Day) (Year)

8. AGE: Years 61 Months 9 Days 12 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name L. F. Walkenhorst
13. Birthplace Blue Heaven (City, town, or county) (State or foreign country) Mo
14. Maiden name Mary L. Hoff
15. Birthplace Germany (City, town, or county) (State or foreign country) Germany

16. (a) Informant Mrs. Henry Walkenhorst

(b) Address New Haven Mo

17. (a) Burial (b) Date thereof 9-9-45
(Burial, cremation, or exposure) (Month) (Day) (Year)

(c) Place: burial or cremation Buried Lutheran Church

18. (a) Signature of funeral director L. F. Hoff

(b) Address Franklin Mo

19. (a) 9/2/45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Franklin
(c) City or town 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 Sept day 6 year 1945 hour 2 am minute _____ M.
21. I hereby certify that I attended the deceased from Sept 3, 45 to _____, 19____, 19____
that I last saw him alive on 9/6/45 and that death occurred on the date and hour stated above.

Immediate cause of death Stroke Duration _____
Crushing of the heart, complicating lung
Due to Medication

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

Major findings: _____
Of operations _____
Of autopsy _____
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) Accident
(b) Date of occurrence Sept 3, 1945
(c) Where did injury occur? Western Franklin Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? On farm, struck by a ball (Specify type of place)
While at work? Yes (e) Means of injury _____

23. Signature [Signature] (M.D. or other) D
Address Washington Mo Date signed 9/2/45

1449

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

Earl Hertig

Licensed Embalmer No.....

P. O. Address

*3385
New Haven*

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.