S. No. 2
M—2-43
. 5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 8 1946

State File No. 40667

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1442

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: At his home. 905 No. 2nd. Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether years, months or days)
In this community Most of his life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 905 North Second Street
(If rural, give location)
(e) Citizen of foreign country? Naturalized (Yes or No)
If yes, name country Germany

3. (a) PRINT FULL NAME CALVIN WILD

3. (b) If veteran, name war No

3. (c) Social Security No. None.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Mollie Wild

6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased Sept- (Month) 4th. (Day) 1864 (Year)

8. AGE: Years 81 Months 3 Days 2 If less than one day hr. min.

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

10. Usual occupation Retired Carpenter.

11. Industry or business ----------

MOTHER FATHER
12. Name Robert Wild
13. Birthplace Germany. (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Katherine Jesberg
15. Birthplace Germany. (City, town, or county) 4 (State or foreign country)

16. (a) Informant Robert Wild
(b) Address 905 North 2nd. Street.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Mrs E. R. Eidenfaden
(b) Address 602 South 10th. Street.

19. (a) Jan 8-46 (Date received by local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec- day sixth. year 1945 hour 8 minute 40 A. M.

21. I hereby certify that I attended the deceased from Dec. 2nd 45, 19..., to Dec. 6 19 45, that I last saw him alive on Dec. 2nd 19 45, and that death occurred on the date and hour stated above.

Immediate cause of death Dysentery — Duration

Due to

Due to

Other conditions Senility
(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)
(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 W. E. Riemer (M. D. or other)
Address 423 Main Str Date signed 12/6/45

1429

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

423 [illegible]
M E [illegible]
4-323

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 Mollie E. Sidenfaden Fox

Licensed Embalmer No. 4235

P. O. Address St. Joseph, 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.