

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19722

State File No. _____

FILED JUL 15 1948

Primary Registration District No. 5183

Registrar's No. 59

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Rural, Beyer Inn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Country Inn 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Entire life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Cape Gir 16
(c) City or town Rural Beyer Inn 0
(If outside city or town limits, write "RURAL")
(d) Street No. 5 miles East of Jackson
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Hulda Volker

3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex female 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 alive _____ years

7. Birth date of deceased: Jan 22 1881
(Month) (Day) (Year)

8. AGE: Years 65 Months 4 Days 17
If less than one day _____ hr. _____ min.

9. Birthplace: Jackson Mo
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

12. Name Frank Volker

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

14. Maiden name Wilhelmina Theodor

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

16. (a) Informant Jane Beattie

(b) Address Jackson Mo

17. (a) Burial (b) Date thereof June 10-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jackson Cemetery

18. (a) Signature of funeral director S. C. Cracraft

(b) Address Jackson

19. (a) 6-10-48 (b) D. S. Subin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
year 1948 hour 2 minute 30 P M.

21. I hereby certify that I attended the deceased from did not attend at all
_____ 19____ to _____ 19____
(That I last saw her alive on June 9 1948
and that death occurred on the date and hour stated above.)

Immediate cause of death Myocarditis
Duration 572

Due to _____

Due to _____

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

Major findings: Of operations _____
Of autopsy 13A

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature D. S. Subin (M. D. or other) MO
Address Jackson Mo Date signed 6-10-48

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

MOTHER FATHER

RECEIVED

Health Officer No. 4
File Number 746-2380
Date Filed 7-13-46

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 Gene C. Crummett

Licensed Embalmer No. 4327

P. O. Address Jackson Ms.

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.

Registration District No. 52

Primary Registration District No. 5183

1. PLACE OF DEATH:

(a) County: Cape Girardeau
(b) City or town: Small
(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
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Hulda Volker

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex: F 5. Color or race: W 6. (a) Single, widowed, married, divorced: S

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

7. Birth date of deceased: Jan 22 1888
(Month) (Day) (Year)

8. AGE: Years 65 Months _____ Days _____ (If less than one day, hr. _____ min. _____)

9. Birthplace: Small, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: Stone

11. Industry or business: Stone

MOTHER FATHER

12. Name _____
13. Birthplace: _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace: _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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 _____ Day _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

TEMPORARY

19722