

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29966**

**FILED SEP 16 1946**

Registration District No. **776**

Primary Registration District No. **5434**

Registrar's No. **88**

1. PLACE OF DEATH:

(a) County **Franklin.**  
(b) City or town **Washington. "Rural" St. John's**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **R. #1 W.**  
(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 **2 yrs.**

3. (a) PRINT FULL NAME **August P. Walkenhorst.**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of ~~husband~~ or wife **Annie Sarah Walkenhorst** 6. (c) Age of ~~husband~~ or wife if alive **69** years  
7. Birth date of deceased **February 10th, 1874**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**72 6 21** hr. min.

9. Birthplace **New Haven, Missouri.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming.**

11. Industry or business **X**

MOTHER FATHER { 12. Name **Herman H. Walkenhorst.** 4  
13. Birthplace **Unknown, Germany.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Wilhelmina Anaphole.**  
15. Birthplace **Unknown, Germany.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Adolph H. Walkenhorst.**  
(b) Address **Washington, Mo.**

17. (a) **Burial** (b) Date thereof **Sept. 5, 1946.**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **New Haven, Mo. R.F.D.**

18. (a) Signature of funeral director **Wilbur L. Pitt, Inc.**  
(b) Address **Washington, Mo.**

19. (a) **9/4/46** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Franklin** 36  
(c) City or town **Washington "Rural"** 6  
(If outside city or town limits, write "RURAL")  
(d) Street No. **R. #1 W.** 0  
(If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country **X**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **2nd.**  
year **1946** hour **3:00** minute **35 A.** M.

21. I hereby certify that I attended the deceased from **Sept 17**  
to **Aug 31**, 19 **46**  
that I last saw him alive on **Aug 31**, 19 **46**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac**  
**decompensation**  
**myocarditis**  
Due to  
Due to

Other conditions **Ch. arthritis**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations  
Of autopsy **935**  
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) (c) Means of injury  
23. Signature **L. O. Murch** (M. D. or other) **MD**  
Address **Washington Mo.** Date signed **9/3/46**

RECEIVED  
District Health Officer No. 9,  
District File Number 9-46-84  
Date Filed 9-9-46

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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed [Signature]

Licensed Embalmer No. 2387

P. O. Address Washington, 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.