

FILED OCT 8 1946

State File No. \_\_\_\_\_

Registration District No. 304

Primary Registration District No. 6046

Registrar's No. 8

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town New Melle, Mo  
(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 None  
(Specify whether \_\_\_\_\_)

In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Charles

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Wilhekmina Kamphoefner

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex F / 5. Color or race W

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

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

7. Birth date of deceased Sept 3th 1852  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20th  
year 1946 hour 9 P.M. minute \_\_\_\_\_

21. I hereby certify that I attended the deceased from Sept 1st 46 to Sept 20 46  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>94</u>		<u>17</u>	hr. _____ min.

Immediate cause of death Carcinoma of Cecum

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace St Charles, Co  
(City, town, or county) (State or foreign country)

10. Usual occupation N.M.O.

11. Industry or business \_\_\_\_\_

12. Name Conrod Weinrich

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

14. Maiden name Anna Nadler

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

Other conditions Initial leak arterio  
(Include pregnancy within 3 months of death)

Major findings: sclerosis Old age dropsy

Of operations \_\_\_\_\_

Of autopsy No autopsy

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Herman Kamphoefner

(b) Address New Melle, Mo.

17. (a) Burial (b) Date thereof Sept 24, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Melle, Mo.

18. (a) Signature of funeral director Marie Munday

(b) Address Wentzville mo

19. (a) Oct 5 1946 (b) Jennie Gersmann  
(Date received local registrar) (Registrar's signature)

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)

Means of injury \_\_\_\_\_

23. Signature Benjamin Brandt (M. D. or other) \_\_\_\_\_

Address Forest Hill Mo. Date signed 9-23-46

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

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 *Marie M. M... ..*

Licensed Embalmer No. *2461*

P. O. Address *Winterville*

**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.**

STATE BOARD OF HEALTH

State File No. oct  
Registrar's No. 8

Registration District No. 304 Primary Registration District No. 6046

1. PLACE OF DEATH:  
(a) County St Charles  
(b) City or town New Melle  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Wilhelmina Kamphofner  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex F 5. Color, or race w 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Sept 3 (Month) (Day) (Year)

8. AGE: Years 94 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St Charles, Mo (City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name Minna Weinnick  
13. Birthplace Germany (City, town, or county) (State or foreign country)  
14. Maiden name Anna Madler  
15. Birthplace Don't know (City, town, or county) (State or foreign country)

16. (a) Informant Herman Kamphofner  
(b) Address New Melle, Mo  
17. (a) Burial (b) Date thereof Sept 24, 1946 (Month) (Day) (Year)  
(c) Place: burial or cremation New Melle Mo  
18. (a) Signature of funeral director Morris Muehlman  
(b) Address Wentzville Mo  
19. (a) Oct 12, 1946 (Date received local registrar) (b) Jennie Gersmann (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County St Charles  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Feb 1, 1946 to Sept 20, 1946  
that I last saw him alive on Sept 19, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death Continuing lacunar Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions mitral leak arteries Sclerosis Edage dropsy  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy no 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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Benjamin Brant (M. D. or other) \_\_\_\_\_  
Address Fairstell Mo Date signed 9, 23, 46

WRITE PLAINLY IN UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

31220