No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29624

FILED SEP 2 1947 818

Registration District No.

Primary Registration District No. 1003

Registrar's No. 7913

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Deaconess Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 36

(c) City or town New Haven 1
(If outside city or town limits, write "RURAL")

(d) Street No. N.R. 0
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Herman William Walkenhorst

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 Louise Walkenhorst

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

7. Birth date of deceased March (Month) 19 (Day) 1864 (Year)

8. AGE: Years 83 Months 5 Days 1 If less than one day hr. min.

9. Birthplace New Haven (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Peter Walkenhorst
13. Birthplace (City, town, or county) Germany (State or foreign country) 4

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

16. (a) Informant Sarah Walkenhorst
(b) Address 1617 Jonquil Dr., Web. Gr., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-47 (Month) (Day) (Year)
(c) Place: burial or cremation New Haven, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) AUG 20 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 20
year 1947 hour 12 minute 40 A.M.

21. I hereby certify that I attended the deceased from Aug 14, 1947, to Aug 20, 1947
that I last saw him alive on Aug 19, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured Gangrenous appendicitis with General peritonitis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Ruptured Gangrenous appendix
Of autopsy

Duration

PHYSICIAN

Underline the cause of 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 0

23. Signature [illegible] (M. D. or other)
Address 714 University Club Bldg Date signed 8-20-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

JUL 8 1948

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. Ernest W. Spicer

Licensed Embalmer No. 4080

P. O. Address.....

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.