S. No. 2
M—8-43
. 5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 11 1947

Registration District No. 119

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37667

Primary Registration District No. 4193

Registrar's No. 25

1. PLACE OF DEATH:
(a) County Gasconade, Co.
(b) City or town Hermann, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Workman Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days (Specify whether years, months or days)
In this community 29 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri. (b) County Montgomery
(c) City or town McKittrick, Mo.
(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 John Volk,
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Fannie Delores Volk,
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 26th (Day) 1853 (Year)

8. AGE: Years	Months	Days	If less than one day
94	8	10	hr. min.

9. Birthplace Gasconade Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Ret Farmer.
11. Industry or business
MOTHER FATHER
12. Name Unknown Volk,
13. Birthplace Unknown (City, town, or county) Germany. (State or foreign country)
14. Maiden name Unknown Unknown,
15. Birthplace Unknown (City, town, or county) Switzerland (State or foreign country)
16. (a) Informant Mrs H. R. Godley
(b) Address McKittrick, Mo. RFD
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8th 1947 (Month) (Day) (Year)
(c) *Place: burial or cremation Loutre Island, Cem
18. (a) Signature of funeral director Paton Gaffer
(b) Address Americus, Mo.
19. (a) 11/7/47 (Date received by local registrar) (b) O. A. Meuschke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 6 year 1947 hour 2:30 minute A M.
21. I hereby certify that I attended the deceased from November 1, 1947, to November 6, 1947, that I last saw him alive on November 6, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Uremia & Urinary Tract infection	Duration
Due to Benign prostatic hypertrophy	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations None	
Of autopsy None	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: None
(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 Carvel T. Shaw, MD. (M. D. or other)
Address Hermann, Mo Date signed 11-7/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 12-10-47

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 D.B.Baker, Registered Apprentice No. , working under my personal supervision.

Signed D.B. Baker

Licensed Embalmer No. 3375

P. O. Address Americus, 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.