

FILED JUL 8 1949

STANDARD CERTIFICATE OF DEATH

State File No. 4533

22371

BIRTH NO. _____ REG. DIST. NO. 364 PRIMARY REG. DIST. NO. 10237 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY Warren		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Warren	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wright City Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wright City Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) George c. (Last) Wahlbrink			4. DATE OF DEATH (Month) (Day) (Year) June 3 1949		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 22 1872	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 11 Days 19
10a. USUAL OCCUPATION (Give kind of work done during past year) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Warren County Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME George Wahlbrink		13b. MOTHER'S MAIDEN NAME Lusette Margaret Wessel		14. NAME OF HUSBAND OR WIFE Minnie Wahlbrink	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Minnie Wahlbrink Wright City Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepato-Renal insufficiency		INTERVAL BETWEEN ONSET AND DEATH 3 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary fibrosis		
	DUE TO (c) Anemia		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Fibrosis			293X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 15, 1949, to June 3, 1949, that I last saw the deceased alive on June 3, 1949, and that death occurred at 1:35 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Mark Campbell M.D.		23b. ADDRESS Wright City Mo.		23c. DATE SIGNED June 3, 1949
24a. BURIAL CREMATATION (Specify)	24b. DATE June 5 1949	24c. NAME OF CEMETERY OR CREMATORY Wright City Cemetery	24d. LOCATION (City, town, or county) (State) Wright City Mo	

DATE REC'D BY LOCAL REG. June 30 '49	REGISTRAR'S SIGNATURE Mrs. F. W. Hughes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Nieburg Furn & Und Co Wright City Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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RECEIVED JUL 6 1919
District Health Officer No. 9,
District No. _____

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Julius J. Nieburg

Licensed Embalmer No.

33676

P. O. Address

Wright City

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.