WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

48968

PLACE OF DEATH

County

Township

or

Village

or

City St Louis (NO. 750 Hamilton Av St.; 28 Ward)

Registration District No. 781 File No.

Primary Registration District No. 1008 Registered No. 12787

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Jacob Henry Wengler

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

~~SINGLE~~ MARRIED ~~WIDOWED~~ OR DIVORCED (Write the word)

DATE OF BIRTH: November 3rd (Month) 1883 (Day) (Year)

AGE: 35 yrs. 1 mos. 2 ds. If LESS than 1 day, ..hrs. or ..min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Deputy Sheriff
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Clayton St Louis Co Mo

PARENTS

NAME OF FATHER: Wm C Wengler

BIRTHPLACE OF FATHER (City or town, State or foreign country): Missouri

MAIDEN NAME OF MOTHER: Lizzie Lamphier

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Allen Wengler

(ADDRESS) Clayton Mo.

Filed DEC 6 1918 Marl C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 5 (Day) 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 1, 1918, to Dec 5, 1918, that I last saw him alive on Dec 5, 1918, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

11 A

10

(Duration) ..yrs. ..mos. 5 ds.

Contributory (SECONDARY)

(Duration) ..yrs. ..mos. ..ds.

(Signed) G. C. Eggers M. D.

Dec 5, 1918 (Address) Clayton

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..yrs. ..mos. 14 ds. In the State 5 yrs. ..mos. ..ds.

Where was disease contracted if not at place of death? 750 Hamilton Av

Former or usual residence Clayton Mo.

PLACE OF BURIAL OR REMOVAL: Valhalla

DATE OF BURIAL: Dec 7, 1918

UNDERTAKER: L J Boff

ADDRESS: Kirkwood Mo

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO. ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191...., that I last saw h.....alive on ....., 191...., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS