

Registration District No. **757**

Primary Registration District No. **3036**

Registrar's No. **46**

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 days
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME GUSTAVE WILKE 420

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anne Strathmann 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased April 14th 1873
(Month) (Day) (Year)

8. AGE: Years 66 Months 10 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace St. Charles, MO (City, town, or county) (State or foreign country) 0

10. Usual occupation Printer 9

11. Industry or business _____

MOTHER FATHER { 12. Name Gertrude Kieck 9

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

14. Maiden name Anderson

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

16. (a) Informant's own signature Gustav E. Wilke

(b) Address 567 Madison St

17. (a) Burial (b) Date thereof Feb 27, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director W. H. ...

(b) Address 326 N. 6th St - St. Charles MO

19. (a) 2/27/40 (b) Clarence A. ...
(Date received local registrar) (Registrar's signature) 9

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 567 Madison
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 24th
year 1940 hour 1 minute 40 P.M.

21. I hereby certify that I attended the deceased from Jan - 31st
31, 1940, to Feb - 24, 1940
that I last saw him alive on Feb 24, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococic Meningitis Duration 3 wks

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Streptococic Meningitis PHYSICIAN _____

Of operations _____ Underline the cause to which death should be charged statistically.
Of autopsy _____

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 J. R. ... (M. D. or other) _____

Address St. Charles MO Date signed Feb 29, 40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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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 Arthur C. Base

Licensed Embalmer No. 3155

P. O. Address St Charles 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7947

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 727

Primary Registration District No. 3036

Registrar's No. 46

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

1. PLACE OF DEATH

(a) County St Charles

(b) City or town St Charles
(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.....
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Gustav Wilke

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 m

6. (b) Name of husband or wife.....

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

66 10 10 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits write "RURAL")

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

(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH Month July day 24
year 1940 hour..... minute..... M.

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

Immediate cause of death Streptococci pneumonia caused by influenza

Due to Streptococci fluid

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 11 B-

Of autopsy.....

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 G. L. Hardin (M. D. or other)

Address St Charles Mo Date signed.....

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

