

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.

REC'D OCT 12 1940
Registration District No. 24

Primary Registration District No. 5779

Registrar's No. 32

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Rural, (outside)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson Missouri P.R. #3
(If not in hospital or institution, write street number or location) W
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME BERTHA WOLFFENKOEHLER
8. (b) If veteran, name war _____ 8. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Henry Wolfenkoebler 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 19 1871
(Month) (Day) (Year)

8. AGE: Years 67 Months 11 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Kennett Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation Housework 6

11. Industry or business _____ 9

MOTHER FATHER
12. Name Wm Wolfenkoebler
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Albert Wolfenkoebler
(b) Address Jackson Mo. P.R. #3

17. (a) Burial (b) Date thereof 9/13/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Johns cemetery

18. (a) Signature of funeral director W. G. Lamb
(b) Address Jackson Mo.

19. (a) 9-16-40 (b) D. S. Herbst
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cape Girardeau
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Jackson Mo P.R. #3
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 12
year 1940 hour 6 minute 5:00 P.M.
21. I hereby certify that I attended the deceased from August 26 1940 to Sept 12 1940
that I last saw her alive on Sept 12 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis of Brain Duration 48 hours

Due to _____

Due to _____

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

PHYSICIAN
Major findings:
Of operations _____
Of autopsy 920
Underline the cause to 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? 120

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R D Blylock (M. D. or other) 1
Address Oak Ridge Mo Date signed 9-14

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 *Thos. V. Allen*.....

Licensed Embalmer No. *4055*.....

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, above space should be left blank.