

FILED SEP 8 1941
Registration District No. **198**

Primary Registration District No. **3011**

1. PLACE OF DEATH:

(a) County **Clay**
(b) City or town **Excelsior Springs**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
McCleary Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 days** **0**
(Specify whether years, months or days)
In this community **6 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Wisconsin** (b) County **999**
(c) City or town **Milwaukee** **43**
(If outside city or town limits, write "RURAL")
(d) Street No. **1560 N. Walker**
(If rural, give location)
(e) Citizen of foreign country? **unknown** (Yes or No)
If yca, name country **A**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **28**
year **1941** hour **6** minute **30.0** M.
21. I hereby certify that I attended the deceased from **19** to **19**
that I last saw **alive on** **19**
and that death occurred on the date and hour stated above.
Immediate cause of death **Embolism of** **Coronary artery.** **Duration**

3. (a) PRINT FULL NAME **Karl Wm. Sonnenberg** **55-397-61-3325**

3. (b) If veteran, name war **unknown** 3. (c) Social Security No. **unknown**

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May** **26** **1888**
(Month) (Day) (Year)

8. AGE: Years **53** Months **3** Days **2** If less than one day _____ hr. _____ min.

9. Birthplace **unknown** **4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Carpenter**

11. Industry or business _____

12. Name **unknown** **9**

13. Birthplace **unknown** **1**
(City, town, or county) (State or foreign country)

14. Maiden name **unknown** **2**

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

16. (a) Informant **Hospital records**

(b) Address **Excelsior Springs, Mo.**

17. (a) **Removal** (b) Date thereof **8-29-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Milwaukee, Wisconsin**

18. (a) Signature of funeral director **Claude Prichard**

(b) Address **Excelsior Springs, Missouri**

19. (a) **Aug 29/1941** (b) **Mrs. R. M. Bracken**
(Date received local registrar) (Registrar's signature)

Due to **minor operation Rely**
Aug 23-1941 **see front**
Due to **bleed into brain**
in front of the McCleary Clinic

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: **with**
Of operations _____
Of autopsy **with**

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?
McCleary Clinic, 6:30 P.M.
(Specify type of place) (a) Means of injury _____
While at work? _____

23. Signature **Bill Prother** **3**
(M. D. or other) _____
Address **Excelsior Springs, Mo** Date signed **8-29-41**

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

SEP 29 1944

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-3-44

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 Robert Ray
Licensed Embalmer No. 4182
P. O. Address Excelsior Spgs., 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.