

FILED JAN 30 1941
Registration District No. 125

Primary Registration District No. 3009

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

1. PLACE OF DEATH:

(a) County Leafe Girardeau

(b) City or town Leafe Girardeau
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Francis Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days (Specify whether years, months or days)

In this community 10 days

3. (a) PRINT FULL NAME BOBBY GENE WESTRICH

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 22 years (Day) (Year)

7. Birth date of deceased Aug 22 1919 (Month) (Day) (Year)

8. AGE: Years 6 Months 3 Days 26 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business

MOTHER FATHER { 12. Name August Westrich

13. Birthplace Scott Co. 0 Mo (City, town, or county) (State or foreign country)

14. Maiden name Louise Blattel

15. Birthplace Scott Co. 0 Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. August Westrich

(b) Address Leafe Hamburg Rd. Scott Co.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22-1941 (Month) (Day) (Year)

(c) Place: burial or cremation New Hamburg Mo.

18. (a) Signature of funeral director Walther Unk. Co

(b) Address Leafe Girardeau Mo.

19. (a) 12-21-41 (Date received local registrar) (b) D. W. Phelps (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott Co.

(c) City or town

(d) Street No. Kelso Hamburg Road (If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 19 year 41 hour 12 minute 0 PM.

21. I hereby certify that I attended the deceased from 12/14 1941 to 12/19 1941 that I last saw 14 alive on 12/19/41 and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis (tubercular)

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 14

Of autopsy

Duration

PHYSICIAN

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?

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

23. Signature [Signature] (M. D. or other) MD
Address Leafe Girardeau Date signed 12/20/41

District Health Officer No. 4
District File Number 142-12
Date Filed 1-15-42

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.....

Licensed Embalmer No.....

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, fact should be so stated above.