

FILED JAN - 5 1943
Registration District No. 292

Primary Registration District No. 4427

Registrar's No. 134

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Wassieles
(c) Name of hospital or institution: De Witt Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community 6 mo
years, months or days

8. (a) PRINT FULL NAME Augusta Wehr

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Dwight Wehr 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
78 5 17 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Herman Schreuter

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

14. Maiden name Esther Braun

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

16. (a) Informant Helen Wehr Compton

(b) Address St James R.

17. (a) Burial (b) Date thereof 12-19-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (a) Signature of funeral director W E Schreuter

(b) Address St James R.

19. (a) 12-17-1942 (b) Chas M. Todd
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps
(c) City or town St James
(If outside city or town limits, write "RURAL")
(d) Street No. Brook Springs Road
(If rural, give location)
(e) If foreign born, how long in U. S. A. 103 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 1942 hour 2 minute 55 PM

21. I hereby certify that I attended the deceased from Dec 15
1942 to Dec 17 1942

that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Respiratory failure

Due to Cerebral Hemorrhage

Due to _____

Other conditions: g3a
(include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

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) Means of injury _____

23. Signature RO Newitt (M. D. or other) MD

Address Waynesville, Mo Date signed 12-17-42

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

RECEIVED

Pulaski County Health Officer

File Number 12-42-219

Date Filed 12-31-42

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.....

me

....., Registered Apprentice No.
working under my personal supervision.

Signed *Chas E Liebler*

Licensed Embalmer No. 3546

P. O. Address St James 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.