

S. No. 2
M-2-43
5-17-39
1' X35697

20916

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 693

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan,

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

(c) Name of hospital or institution:
Missouri Methodist Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 days,
(Specify whether

In this community 24 days,
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas, (b) County Doniphan

(c) City or town White Cloud, 999
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 14

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____ 2

3. (a) PRINT FULL NAME Gus William Windmeyer

3. (b) If veteran, name war None,

3. (c) Social Security No. None,

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Minnie Windmeyer,

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased April 23rd, 1886
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>1</u>	<u>26</u>	hr. _____ min.

9. Birthplace Arrow Rock, Missouri, 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer,

11. Industry or business Farm,

12. Name Fred William Windmeyer,

13. Birthplace Unknown, Illinois, 1
(City, town, or county) (State or foreign country)

14. Maiden name Nettie Holtman,

15. Birthplace Unknown, Germany, 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Gus W. Windmeyer

(b) Address White Cloud, Kansas

17. (a) Removal (b) Date thereof 6/19/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highlan, Kansas,

18. (a) Signature of funeral director Rose Hezyog

(b) Address 319 So. 10th. Street, Home

19. 6/19/43 (b) Rose Hezyog
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19th.
year 1943 hour 5:00 minute 30 p. M.

21. I hereby certify that I attended the deceased from 5-20-43
_____ 19____ to 6-19- 1943
that I last saw h. in alive on 6-19- 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Mesenteric Thrombosis Duration 1 wk.

Due to Pneumonia, general 17 mo.

Due to Ruptured appendix 5 wk.

Other conditions 12/11
(include pregnancy within 3 months of death)

Major findings: Mesenteric Thrombosis PHYSICIAN _____

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

Of autopsy None

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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature Paul Jorgensen (M. D. or other) _____

Address St Joseph, Mo Date signed 6-20-43

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

MOVER FATHER

Dr. Paul Forgrave
731 Falson

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.....

James A. Moles

Licensed Embalmer No. *3296*

P. O. Address *St Joseph, 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.