

FILED DEC 1 1943

State File No. _____

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 1291

1. PLACE OF DEATH

(a) County Buchanan
(b) City or town St Joseph MO
(c) Name of hospital or institution State Hosp #2
(d) Length of stay: In hospital or institution hosp 42 yrs
In this community Same

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Saline
(c) City or town Slater
(d) Street No. _____
(e) Citizen of foreign country? NO

3. (a) PRINT FULL NAME Alice Wenzel

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

4. Sex F 1 5. Color or race W 9 6. (a) Single, widowed, married, divorced, or never married do not know

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

7. Birth date of deceased do not know

8. AGE: Years 70 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace unknown MO

10. Usual occupation None

11. Industry or business _____

12. Name Not on record 9

13. Birthplace _____

14. Maiden name Not on record 9

15. Birthplace _____

16. (a) Informant Admission papers

(b) Address State Hosp #2

17. (a) R (b) Date thereof 11-14-43

(c) Place: burial or cremation Mt Holly near Slater MO

18. (a) Signature of funeral director Ernest Baker

(b) Address Slater MO

19. (a) 11-14-43 (b) Rose Heitz

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov, day 14 year 1943 hour 4 minute 09 A.M.

21. I hereby certify that I attended the deceased from _____ to _____ that I last saw her _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Do not know

Due to _____

Due to _____

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

Major findings: Of operations _____

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? _____

(d) How and 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 E H Mancee (M. D. or other) Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

DEC 1 1948

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.

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(c) Name of hospital or institution: State Hospital #2
(d) Length of stay: In hospital or institution.....
In this community.....

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town.....
(d) Street No.....
(e) Citizen of foreign country?.....

3. (a) PRINT FULL NAME Abie Wenzee
3. (b) If veteran, name war..... 3. (c) Social Security No.....

20. DATE OF DEATH: Month Nov year 1943 hour..... minute..... M.
21. I hereby certify that I attended the deceased from.....
that I last saw him.....
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

Immediate cause of death found dead in bed probably due to acute cardiac dilatation.

7. Birth date of deceased.....
8. AGE: Years 70 Months..... Days.....

Due to.....
Due to.....
Other conditions (include pregnancy within 3 months of death).....

9. Birthplace.....
10. Usual occupation.....

Major findings: 9504
Of operations.....
Of autopsy.....

11. Industry or business.....
12. Name.....
13. Birthplace.....
14. Maiden name.....
15. Birthplace.....

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?.....
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

16. (a) Informant..... (b) Address.....
17. (a) (Burial, cremation, or removal)..... (b) Date thereof.....
(c) Place: burial or cremation.....
18. (e) Signature of funeral director..... (b) Address.....
19. (a) (Date received local registrar)..... (b) (Registrar's signature).....

While at work?..... (Specify type of place)
(e) Means of injury BP Mag ce
23. Signature..... (b) Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN Underline the cause to which death should be charged statistically.

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