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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37942**

Registration District No. **1513**

Primary Registration District No. **3009**

Registrar's No. **41**

1. PLACE OF DEATH:

(a) County Cape Girardeau

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether)

In this community 1
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau

(c) City or town OILC
(If outside city or town limits, write "RURAL")

(d) Street No. Union Ave
(If rural, give location)

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

3. (a) PRINT FULL NAME ANNIE WILLE

3. (b) If veteran, name war ()

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27th
year 1943 hour 6 minute 00 a.m.

21. I hereby certify that I attended the deceased from Aug
1943 to Nov 27, 1943;
that I last saw her alive on Nov 26, 1943
and that death occurred on the date and hour stated above.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife William Wille

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

7. Birth date of deceased Dec 17 1883
(Month) (Day) (Year)

Immediate cause of death Intestinal Carcinoma

Duration 3-4 mo

8. AGE: Years 62 Months 11 Days 10
If less than one day hr. min.

Due to ?

Due to ?

Other conditions Intestinal obstruction 3 day
(Include pregnancy within 3 months of death)

MOTHER FATHER

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

10. Usual occupation House work

11. Industry or business

12. Name Herbinaud Paloff

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

14. Maiden name Augusta Logg

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

16. (a) Informant Mrs Esther Schaefer

(b) Address Jackson mo

17. (a) Burial (b) Date thereof 11/29/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Russell Heights

18. (a) Signature of funeral director M E Crumbo & Co

(b) Address Jackson mo

19. (a) 11/29 1943 (b) J H Keister
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Major findings: 46

Of operations ()

Of autopsy ()

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) (c) Means of injury ()

23. Signature T. E. Ruff (M. D. or other) MD

Address Jackson mo Date signed 11-30-43

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

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4
District File Number 1243-299
Date Filed 12-7-43

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 Thos. W. Allen

Licensed Embalmer No. 4055

P. O. Address Jackson

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec
Registrar's No. 41

Registration District No. 52 Primary Registration District No. 3009

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Jackson
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Annie Will
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 W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Dec 17 (Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days _____ If less than one day _____ min.
9. Birthplace Mo. (City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) 11/27 1943 (Date received local registrar) (b) J. G. Kestner (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Cape Girardeau
(c) City or town Jackson (If outside city or town limits, write "RURAL")
(d) Street No. Union Ave (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH: Month Dec year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy _____
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) (c) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

37942