DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 31 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1776

Registration District No. 42 | Primary Registration District No. 1 200 | Registrar's No. 66

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Dr. Hartsock Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)
In this community 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Andrew
(c) City or town Near Rosendale (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Adolph Uelligger
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex M. D
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Martha Mary Uelligger
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Jan (Month) 31 (Day) 1876 (Year)

8. AGE: Years	Months	Days	If less than one day
68	11	26	hr. min.

9. Birthplace Burn (City, town, or county) Switzerland (State or foreign country)
10. Usual occupation Farmer
11. Industry or business ~~John Uelligger~~
MOTHER FATHER
12. Name John Uelligger
13. Birthplace un Known (City, town, or county) Switzerland (State or foreign country)
14. Maiden name Marie Gander
15. Birthplace un Known (City, town, or county) Switzerland (State or foreign country)
16. (a) Informant Mrs. Martha M Uelligger
(b) Address Rosendale Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Fillmore
18. (a) Signature of funeral director E. C. Breit
(b) Address Savannah Mo
19. (a) 1-29-45 (Date received local registrar) (b) Helen J Beebe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 27 year 1945 hour 6 minute 45 P. M.
21. I hereby certify that I attended the deceased from Jan 18, 1945 to Jan 27, 1945 and that I last saw him alive on Jan 27, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Epistaxis + Cerebral Hemorrhage	9 Day
Due to Arteriosclerosis	?
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Clifford L Steadley M. D. or other) DO.
Address Dearmonch Mo Date signed 1/29/45

1571 (Licensed Embalmer's Statement on Reverse Side)

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

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 E. C. Breit

Licensed Embalmer No. 2630

P. O. Address Saco, Maine

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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5-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No.

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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 (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME Adolph Heligger
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 31 (Day) 1877 (Year)
8. AGE: Years 68 Months 4 Days 26 If less than one day hr. min.
9. Birthplace Lenz (City, town, or county) Switzerland (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name John Heliggen
13. Birthplace no record (City, town, or county) Switzerland (State or foreign country)
14. Maiden name Marie Gandels
15. Birthplace no record (City, town, or county) Switzerland (State or foreign country)
16. (a) Informant Mrs Adolph Heliggen
(b) Address Rosendale, Mo.
17. (a) B (Burial, cremation, or removal) (b) Date thereof 1-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Fillmore Mo.
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

1776