Dr. Horton

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 26 1946

State File No. 2783

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 16

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

695

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: St. Johns Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 Days (Specify whether In this community 4 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield (If outside city or town limits, write "RURAL") 2

(d) Street No. 1112 N. Grant (If rural, give location) 6

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Ann Mary Wucherpfennig

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Joseph F. Wucherpfennig

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

7. Birth date of deceased Oct. (Month) 18, (Day) 1878 (Year)

8. AGE: Years	Months	Days	If less than one day
✓ 67	2	17	hr. min.

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

10. Usual occupation Home

11. Industry or business

FATHER
12. Name Adam Breier
13. Birthplace UNK (City, town, or county) Germany (State or foreign country) 4

MOTHER
14. Maiden name Elizzbeth Arnold
15. Birthplace Randolph (City, town, or county) Ohio (State or foreign country) 1

16. (a) Informant Margaret Ann Wucherpfennig

(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46 (Month) (Day) (Year)

(c) Place: burial or cremation Billings, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 1-7-46 (Date received local registrar) (b) O. W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5 year 1946 hour 10:00 minute p. M.

21. I hereby certify that I attended the deceased from 12/21/45, 19 to 1/5/46, 19; that I last saw her alive on 1/5/46, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Ileus, paralytic — Duration 1 wk.

Due to

Due to

Other conditions (1) Fracture, intertrochanteric right femur (2) Foecal impaction (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) 22

(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 Denis D. Horton (M. D. or other)

Address Springfield, Mo. Date signed 1/6/45

(Licensed Embalmer's Statement on Reverse Side)

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 Walter E. Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield Mo

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

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

X

No. 2B
—3-45
PI X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7 et

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 16

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(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
In this community years, months or days)

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 Ann M. Wuchepfenning
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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 18 (Day) 1878 (Year)
8. AGE: Years 67 Months 2 Days 7 If less than one day hr. min
9. Birthplace (City, town, or county) Ohio (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1946 hour 8 minute 20 P.M.
21. I hereby certify that I attended the deceased from 12/21/45 to 1/5/46, 19..; that I last saw him alive on 1/5/46, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Paralytic ileus	5 days
Due to (2) Fecal impaction	6 days
Due to (3) Fracture, comminuted, intertrochanteric, R femur	
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) accident
(b) Date of occurrence 12/20/45
(c) Where did injury occur? Billings Christian Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Fell at home (Specify type of place)
While at work? No (e) Means of injury Fall
23. Signature James D. Boynton M.D. (M.D. or other)
Address Springfield Mo. Date signed 2/2/46

SUPPLEMENTARY

INITIAL SUPPLEMENTARY INFORMATION REQUESTED

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

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