

No. 2
9-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 27 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 277732
Registrar's No. 138

Registration District No. 206 Primary Registration District No. 3042

1. PLACE OF DEATH:
(a) County Madison
(b) City or town Fredericktown
(c) Name of hospital or institution: 1
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution Life
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Madison
(c) City or town Fredericktown Mo
(d) Street No. 319 Anthony
(e) Citizen of foreign country? ✓
If yes, name country ✓

3. (a) PRINT FULL NAME MARY ALICE WERNECKER
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month Aug day 21
year 1946 hour 9 minute 15 P.
21. I hereby certify that I attended the deceased from Oct 10
1945, to Aug 21, 1946
that I last saw her alive on Aug 21
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 W.
6. (b) Name of husband or wife Henry Wernecker
6. (c) Age of husband or wife if alive 100 years
7. Birth date of deceased March, 10 1861
(Month) (Day) (Year)

Immediate cause of death Senile Debility
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

8. AGE: Years Months Days If less than one day
85 5 12 hr. _____ min.

9. Birthplace Madison Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER
12. Name John Ray
13. Birthplace Tenn.
14. Maiden name Sarah Jones
15. Birthplace Tenn.

16. (a) Informant C. C. Wernecker

(b) Address Fredericktown, Mo

17. (a) Burial (b) Date thereof 8/24/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Christian Cemetery

18. (a) Signature of funeral director Webb & Nolt

(b) Address Fredericktown, Mo

19. (a) 8-27-46 (b) Florence Fisher
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(c) 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) (e) Means of injury 2
23. Signature Keith L. Hull (M. D. or other) D.O.
Address Fredericktown, Mo. Date signed 8-22-46

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

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

26570

RECEIVED

District Health Officer No. 4
District File Number 846-2527
Date Filed 8-26-46

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 John H. Holt

Licensed Embalmer No. 4264

P. O. Address Fredericktown, Md

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. 206

Primary Registration District No. 3042

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Fredericktown
(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)

3. (a) PRINT FULL NAME May A. Wernicker

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 Mar. 10 (Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 10 If less than one day _____ hr. _____ min.

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-24-1946 (Date received local registrar) (b) Florence Dickes (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1946 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

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

Address _____ Date signed _____

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

SUPPLEMENTARY

1.

jos

27732