

7. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
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34564

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED OCT 8 1946  
Registration District No. 306

Primary Registration District No. 6048

Registrar's No. 264

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Peters rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(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 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles

(c) City or town St. Peters rural 92  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

3. (a) PRINT FULL NAME Joseph John Wilke

3. (b) If veteran, name war: \_\_\_\_\_ (c) Social Security No. 488 26 1510

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2  
year 1946 hour betw. 6-8 minute P.M. 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: suicide

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.

8. AGE:

Years	Months	Days	If less than one day
<u>37</u>	<u># 1</u>	<u>27-</u>	hr. _____ min. _____

Due to gunshot wound by his own act

Due to \_\_\_\_\_

9. Birthplace O'Fallon, Mo.  
(City, town, or county) (State or foreign country)

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

10. Usual occupation Truck Driver

Of autopsy no

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name John Wilke

13. Birthplace St. Peters, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Agnes Schwendemann

15. Birthplace St. Peters, Mo.  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence Oct. 2nd, 1946

(c) Where did injury occur? farm near his home  
(City or town) (County) (State)

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

16. (a) Informant Nettie Wilke

(b) Address St. Peters, Mo.

17. (a) Burial (b) Date thereof Oct. 5, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters, Mo.

While at work? no (Specify type of place) \_\_\_\_\_ (e) Means of injury shotgun

23. Signature Marie M. ... (Name of embalmers)  
Address St. Peters, Mo. Date signed Oct 3, 46

18. (a) Signature of funeral director Geo. Stupfater

(b) Address St. Peters, Mo.

19. (a) Oct 4 - 46 (b) E. A. Ruthley  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

72  
0  
0

290

Filed 10-8-46

District File Number

District Health Officer No. 9,

RECEIVED

OCT 21 1946

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. K. Keithly

Licensed Embalmer No. 822

P. O. Address Fallow Mo

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.