

FILED MAR 12 1947

Registration District No. _____

Primary Registration District No. **3054**

Registrar's No. **17**

1. PLACE OF DEATH:

(a) County **Pike Louisiana**
(b) City or town _____
(c) Name of hospital or institution: **316 1/2 Georgia St. /**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **70 Years** (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pike**
(c) City or town **Louisiana**
(If outside city or town limits, write "RURAL")
(d) Street No. **316 1/2 Georgia St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **EMMA SOELLINGER WAHL**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Charles Wahl** 6. (c) Age of husband or wife if alive **Deceased** years

7. Birth date of deceased **April 5 1885**
(Month) (Day) (Year)

8. AGE: Years **81** Months **10** Days **8** If less than one day hr. min.

9. Birthplace **Keokuk Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Housekeeping**

12. Name **Moritz Soellinger**

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

14. Maiden name **Louise Chartre**

15. Birthplace **Paris France**
(City, town, or county) (State or foreign country)

16. (a) Informant **Clarence Wahl**

(b) Address **Louisiana Missouri**

17. (a) **Burial** (b) Date thereof **Feb. 13, '47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Riverview Cemetery**

18. (a) Signature of funeral director **Garner & Sterne**

(b) Address **Louisiana Missouri**

19. (a) **2-12-47** (b) **Bernice Collier**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **11**
year **1947** hour **9** minute **30 p** M.

21. I hereby certify that I attended the deceased from **2-11 1947** to **2-10 1947**
that I last saw her alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death: **Broncho-pneumonia**
Hypertension
Chronic Nephritis
Due to _____
Due to _____
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: **93D**
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at _____ (Specify type of place)
(c) Means of injury _____
23. Signature **[Signature]** (M. D. _____)
Address **[Address]** Date signed **2-12-47**

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

RECEIVED
District of Columbia
Date Filed MAR 11 1947
No. 10
247-486

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.....

Virginia M. Sterne....., Registered Apprentice No. 491
working under my personal supervision.

Signed J. B. Sterne.....

Licensed Embalmer No. 4039.....

P. O. Address Louisiana, 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.