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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 19 1947

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 20523

Registration District No. 110

Primary Registration District No. 4182

Registrar's No. 43

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Georgetown mo  
(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 20 years  
years, months or days

3. (a) PRINT FULL NAME HILDA WESSELL

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

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Feb 25 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
55 3 16 hr. min.

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

10. Usual occupation None

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

MOTHER FATHER  
12. Name Geo Wessell 4  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Josephine Meyer  
15. Birthplace Franklin Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Lelara Wessell  
(b) Address St Louis Mo

17. (a) Burial (b) Date thereof 6-13-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pond Thunders Eng

18. (a) Signature of funeral director W. L. Heritage

(b) Address New Haven Mo

19. (a) June 12 (b) Jeffie Wessell  
(Date received local registrar) (Registrar's signature) 93

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 36  
(c) City or town New Haven VI  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years. 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11  
year 1947 hour 12:50 minute P. M.

21. I hereby certify that I attended the deceased from Dec 1 1946, to June 11 1947;  
that I last saw her alive on June 11 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Epilepsy Duration 10 yrs

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

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

Other conditions Cretinism  
(Include pregnancy within 3 months of death)

Major findings: 45  
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 2

23. Signature Jeffie Wessell (M. D. or other) D. O.  
Address New Haven, Mo. Date signed 6/12/47

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

RECEIVED  
District Health Officer No. 5  
District File Number  
Date Filed 6-18-47

**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 Carl Fertig  
Licensed Embalmer No. 3385  
P. O. Address Yerushalmi 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, above space should be left blank.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JulyRegistration District No. 110Primary Registration District No. 4182Registrar's No. 430

## 1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town New Haven  
(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 days3. (a) PRINT  
FULL NAME Hilda Wessel3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex F 5. Color or race W 6. (a) Single, widowed, married,  
divorced S6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_7. Birth date of deceased Jan 21 1921  
(Month) (Day) (Year)8. AGE: Years 55 Months 3 Days \_\_\_\_\_ 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 \_\_\_\_\_

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Jeffie W. Trammann  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Franklin(c) City or town New Haven, Mo.  
(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 \_\_\_\_\_  
year 19 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 sta-  
tistically.

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

S-20523