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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26998

FILED SEP 9 1947

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 2167

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

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau Mo.

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

(d) Length of stay: In hospital or institution 3 days
In this community About 3 days
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Perry

(c) City or town Uniontown Mo
(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 Judith Ann Wichern

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 Single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased August 30 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

3 hr. min.

9. Birthplace Cape Girardeau Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Inf

11. Industry or business _____

12. Name Alphons Wichern

13. Birthplace Perry Co., Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Helen Dornstardt

15. Birthplace ILL.
(City, town, or county) (State or foreign country)

16. (a) Informant Alphons Wichern

(b) Address Uniontown Mo.

17. (a) Burial (b) Date thereof 9-2-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Uniontown Mo.

18. (a) Signature of funeral director Young & Sons

(b) Address Perryville Mo.

19. (a) 9-4-47 (b) C. C. Summers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 1
year 1947 hour 1 minute _____ P. M.

21. I hereby certify that I attended the deceased from Aug. 30, 1947 to Sept 1, 1947
that I last saw her alive on 2/1, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Repeated Miliary

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)

(c) Means of injury _____

23. Signature Chas. J. Herlihy (M. D. or other)
Address Cape Girardeau Mo. Date signed 9/4/47

RECEIVED

District Health Officer No. 4
District File Number 947-1159
Date Filed 9-8-47

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 Wallace Young
Licensed Embalmer No. 7827
P. O. Address Perisville 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.