

1 PLACE OF DEATH County of <u>McLean</u> <u>Normal</u>	Registration Dist. No. <u>690</u>
*Township *Road Dist. *Village *City Primary Dist. No. <u>5046</u>	
*(Cancel the three terms not applicable —Do not enter "R. R.," "R. F. D.," or other P. O. address). Street and Number, No. _____ St.; _____ Ward, _____ Hospital.	

STANDARD CERTIFICATE OF DEATH

Registered No. 139
 (Consecutive No.)

2 FULL NAME Albert Wilke
 (a) Residence No. 1507 N. Franklin St.; _____ Ward, Bloomington Ill
 (Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word)		
5a If married, widowed or divorced HUSBAND of (or) WIFE of <u>Caroline Wilke</u>		6 DATE OF BIRTH <u>4</u> <u>19</u> <u>865</u> (Month) (Day) (Year)		
7 AGE Years <u>61</u>	Months <u>4</u>	Days <u>29</u>	If LESS than 1 day _____ hrs. OR _____ min.?	
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer.				
9 BIRTHPLACE (city or town) <u>Germany</u> (State or Country).				
PARENTS	10 NAME OF FATHER <u>August Wilke</u>			
	11 BIRTHPLACE OF FATHER (city or town) _____ (State or Country) <u>Germany</u>			
	12 MAIDEN NAME OF MOTHER			
	13 BIRTHPLACE OF MOTHER (city or town) _____ (State or Country) <u>Germany</u>			
14 INFORMANT <u>Carrie Carlson</u> (personal signature with pen and ink) P. O. Address <u>Bloomington Ill</u>				
15 Filed <u>9/25</u> <u>26</u> P. O. Address <u>Normal</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH		
16 DATE OF DEATH <u>9</u> <u>23</u> <u>26</u> (Month) (Day) (Year)	17 I HEREBY CERTIFY That I attended deceased from <u>19</u> <u>26</u> to <u>19</u> <u>26</u> that I last saw him <u>alive</u> on <u>9-23</u> <u>19</u> <u>26</u> and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Carcinoma of Rectum</u>	
CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.		
18 Where was disease contracted, if not at place of death? Was an operation performed? _____ Date of _____ For what disease or injury? _____ Was there an autopsy? _____ What test confirmed diagnosis? _____ (Signed) <u>E. L. Brown</u> M. D. Address <u>Bloomington Ill</u> Date <u>9-24</u> <u>19</u> <u>26</u> Telephone _____		
*N. B.—State the disease causing death. All cases of death from "Violence, casualty, or any undue means" must be referred to the coroner. See Section 10, Coroner's Act.		
19 PLACE OF BURIAL OR REMOVAL <u>Park Hill cem.</u>	21 DATE OF BURIAL <u>9-25</u> <u>26</u>	
20 UNDERTAKER <u>Flinspach</u> (personal signature with pen and ink) (firm name, if any)	ADDRESS <u>Bloomington Ill</u>	

FOR GENEALOGICAL PURPOSES ONLY

I HEREBY CERTIFY THAT the foregoing is a true and correct copy of the record for the person named and that this record was established and filed in my office in accordance with the provisions of the Illinois Statutes relating to the registration of births, stillbirths, deaths, and marriages.

DATE: AF. 02 2003

AT: Bloomington, Illinois

SIGNED: Peggy Ann Milton
 OFFICIAL TITLE: McLean County Clerk

The original record is permanently filed with the ILLINOIS DEPARTMENT OF PUBLIC HEALTH at Springfield. Local Registrars are authorized to make certifications from copies of the original record. The Illinois Statutes provide that the certification of this record by the Department of Public Health or the Local Registrar shall be prima facie evidence in all courts and places of the facts therein stated.