

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE DEPARTMENT  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

25451

1. PLACE OF DEATH  
County Pettis Registration District No. 669 File No. \_\_\_\_\_  
Township Lark Creek Primary Registration District No. 5897 Registered No. 8  
City \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Mary Elizabeth Meller  
(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
76 6 12 — —

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Housework  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Pettis Co Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Peter Meller

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Jessie Rensch

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany  
(STATE OR COUNTRY)

14. INFORMANT Ed Eickhoff  
(Address) Colo Camp Mo

15. FILED July 7 1929 Mrs J L Monsees  
REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7 - 2 19 29

17. I HEREBY CERTIFY That I attended deceased from 3-10 19 29 to 7-2 19 29  
that I last saw him alive on 7-1 19 29, and that death occurred, on the date stated above, at 6 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

chron Nephritis

12 1/2 fibrous tumor (duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 12 1/2  
IF NOT AT PLACE OF DEATH, No  
DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms  
(Signed) E. L. Eickhoff M. D.  
7/2/29, 19 (Address) Colo Camp Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
Bayner Cem. July 4 1929  
20. UNDERTAKER ADDRESS  
E. L. Eickhoff Colo Camp Mo

# MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County.....  
Township.....  
City..... (No. ....)

Registration District No. .... File No. ....  
Primary Registration District No. .... Registered No. ....  
City..... St. .... (Word) .....

## 2. FULL NAME

(a) Residence, No. .... St. ....  
(Usual place of abode) yr. mos.

Ward. ....  
da. How long in U.S., if of foreign birth? yr. mos. da.  
(If nonresident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX ..... 4. COLOR OR RACE ..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) .....

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF .....

6. DATE OF BIRTH (MONTH, DAY AND YEAR) .....

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. ....

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....  
(STATE OR COUNTRY) .....

## 10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....  
(STATE OR COUNTRY) .....

## 12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....  
(STATE OR COUNTRY) .....

## PARENTS

14.

INFORMANT .....  
(Address) .....

15.

FILED ..... 19 ..... REGISTRAR .....

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) ..... 19 .....

17.

I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19 ....., and that that I last saw him alive on ..... 19 ....., and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) .....

18. WHERE WAS DISEASE CONTRACTED .....

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) .....

, 19 (Address) .....

M. D

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL .....

DATE OF BURIAL .....

20. UNDERTAKER .....

ADDRESS .....