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

Do not use this space.

39651

1. PLACE OF DEATH

County: Benton — Registration District No.: 59 — File No.:

Township: Williams — Primary Registration District No.: 5094 — Registered No.: 26

City: ..... (No. ..... St. ..... Ward)

2. FULL NAME Marie Meyer Monsees

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 4-4-1850

7. AGE: 79 YEARS | 9 MONTHS | 29 DAYS | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Ollrich Meyer

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

12. MAIDEN NAME OF MOTHER: Catherine Cordes

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

14. INFORMANT: John Monsees
(Address): Cole Camp Mo

15. FILED 1-2-1930 Harry Bay
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12-3-29 19

17. I HEREBY CERTIFY, That I attended deceased from 11-15-1929, to 12-3-1929, that I last saw her alive on 12-3-1929, and that death occurred, on the date stated above, at 11:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
10K
10 [illegible]
(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (SECONDARY): Hypostatic Pneumonia
(duration) ..... yrs. ..... mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? At Home
DID AN OPERATION PRECEDE DEATH? No DATE OF X
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) [illegible], M. D
12-4, 1929 (Address) Cole 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Cheese Creek — DATE OF BURIAL: 12-8 1929

20. UNDERTAKER: E L Eickhoff — ADDRESS: Cole Camp Mo

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.