

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.

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5
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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

30311
Do not use this space.

1. PLACE OF DEATH

(a) County Saline Registration District No. 796

(b) Township 1 Primary Registration District No. 3038

(c) City Marshall, Mo. (d) Street No. Fitzgibbons Hospital Registered No. 143

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

2. PRINT FULL NAME Mary Ann Meier

(a) Residence, No. 403-North Beroy St St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January-5-1859

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>80</u>		<u>7</u>	<u>22</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Work

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Milwaukee, Wisconsin

FATHER

13. NAME Patrick Deibel

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Theresa Wunderlich

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Mrs. Inna May Lenz
(ADDRESS) Slater, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Bethel-Near Slater-Aug-29-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jones & Salzer Slater Mo

20. FILED 8-29-39 Mary Kent
Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August-27-39

22. I HEREBY CERTIFY, That I attended deceased from Aug 23rd 1939, to Aug 27 1939

I last saw him/her alive on Aug 27 1939 Death is said to have occurred on the date stated above, at 4:40 PM

The principal cause of death and related causes of importance were as follows:

Hypersthenic Pneumonia
Interstitial Nephritis
Intertracheal fracture of left femur

Date of onset 8-27-39

Other contributory causes of importance:
Intertracheal fracture of left femur

Name of operation No Op Date of 8-23-39

What test confirmed diagnosis? Ray-Lab Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury 8-23-39

Where did injury occur? at home Slater Mo
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. at home

Manner of injury fell on his hip

Nature of injury intertracheal fracture

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify The E. Lenz (Signed) _____, M. D.

(Address) Slater Mo

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9/12/38

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 _____
Licensed Embalmer No. _____
P. O. Address _____

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.