

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.

Registration District No. 784 Primary Registration District No. 2nd

1. PLACE OF DEATH:
 (a) County St. Louis County 2
 (b) City or town Robertson, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County St. Louis
 (c) City or town Robertson
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)

3. (a) PRINT FULL NAME Chas. August Mensendiek 525
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male **5. Color or** White **6. (a) Single, widowed, married,** Married
6. (b) Name of husband or wife Amalia **6. (c) Age of husband or wife if** 70 **alive** 70 **years**
7. Birth date of deceased Sept. 5th, 1865
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>		<u>I</u>	hr. _____ min.

9. Birthplace _____ Germany
 (City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business _____
FATHER { **12. Name** Frederick Mensendiek 6
13. Birthplace Germany 1
 (City, town, or county) (State or foreign country)
MOTHER { **14. Maiden name** Johanna Wittenborn
15. Birthplace _____ Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Chas. Mensendiek
(b) Address Robertson, Mo.
17. (a) St. Peters **(b) Date thereof** Sept. 9th, 1939
 (Burial, cremation, or other disposal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters
18. (a) Signature of funeral director Kraeger-Voss-Fix, I
(b) Address 3402 N. Kingshighway
19. (a) SEP 9 1939 **(b)** _____
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 6th, 1939
22. I HEREBY CERTIFY, That I attended deceased from June 1st, 1939, to September 6th, 1939
 I last saw him alive on September 6th, 1939. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage
8201
 Other contributory causes of importance:
Arteriosclerosis
 Date of onset 9-2-39
9.1.38

Name of operation _____ **Date of** _____
What test confirmed diagnosis? Chemical **Was there an autopsy?** No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ **Date of injury** _____, 19____
Where did injury occur? _____
 (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) _____ **M. D.**
(Address) _____

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 Albert N. Happe

•Licensed Embalmer No: 1861

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.