

JAN 12 1940

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

44471
Do not use this space.

1. PLACE OF DEATH *St. Charles 2*
(a) County *St. Charles* Registration District No. *759*
(b) Township *Callaway 1* Primary Registration District No. *6000*
(c) City *Westzville* (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred *6* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Frank Adolph Meineshagen*
(a) Residence, No. _____ 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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Missie Meineshagen*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 1st 1884*
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
55 2 23
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*
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) *Warrenton Mo.*
13. NAME *August Meineshagen*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Warrenton Mo.*
15. MAIDEN NAME *Emma Meineshagen*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Warrenton Mo.*
17. INFORMANT (ADDRESS) *Missie Meineshagen Westzville Mo*
18. BURIAL, CREMATION, OR REMOVAL PLACE *New Mellis* DATE *12-27* 19*39*
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *J. P. Turner Westzville Mo.*
20. FILED *2-27* 19*39* *Oct. Mahan* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 24 1939*
22. I HEREBY CERTIFY, That I attended deceased from *Dec 24* 19*39*, to *Dec 25* 19*39*.
I last saw him alive on *Dec 24* 19*39*. Death is said to have occurred on the date stated above, at *6 A.M.*
The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia
Date of onset _____
Other contributory causes of importance: *1)*
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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? _____
If so, specify _____
(Signed) *Russ Miller* M. D.
(Address) *Foristell Mo*

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FORM 9-19-38 I X-16603

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.....

R. C. Peterson

Licensed Embalmer No. *2711*

P. O. Address *Wentzville, Mo.*

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.