

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

2311  
 Do not use this space.

**FILED FEB 7 1940**

1. PLACE OF DEATH  
 (a) County Franklin Registration District No. 1104  
 (b) Township Boone Primary Registration District No. 5415  
 (c) City Boone (d) Street No. \_\_\_\_\_ St.  
 (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 Marie C. Meyer  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female  
 4. COLOR OR RACE white  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND or (OR) WIFE OF August C. Meyer  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 16, 1874  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
65 11 4  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 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) Jeffersburg Mo  
 FATHER  
 13. NAME Frank Lottmann  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jeffersburg Mo  
 MOTHER  
 15. MAIDEN NAME Thelminia Biermann  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Casco Mo  
 17. INFORMANT (ADDRESS) Therley J. Joelke, Gerald Mo.  
 18. BURIAL, CREMATION, OR REMOVAL Leake M. G. Cent DATE Jan 22, 40  
 19. FUNERAL DIRECTOR (ADDRESS) Beaufort Mo  
 20. FILED 1-21, 1940 Chas A Schmidt Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-19 1940  
 22. I HEREBY CERTIFY, That I attended deceased from Jan. 16 1940 to Jan. 19 1940  
 last saw her alive on Jan 17 1940. Death is said to have occurred on the date stated above, at 11 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Lobular Pneumonia Date of onset \_\_\_\_\_  
 Other contributory causes of importance: 10 1/2  
 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) B. O. Meyer, M. D.  
273 (Address) Gerald 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.

THIS IS A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I, E. H. Jenne....., Licensed Embalmer No. 3076

hereby certify that the body recorded on the reverse side of this certificate was embalmed by E. H. Jenne

..... L. E. ....

No. .... or by ..... Registered Apprentice No. ....

working under my personal supervision.

Signed E. H. Jenne

Licensed Embalmer No. 3076

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

2311

Do not use this space.

1. PLACE OF DEATH: (a) County Franklin Registration District No. 1104  
 (b) Township Boone Primary Registration District No. 3415  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered No. 2  
 (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: Marie C. Meyer  
 (a) Residence, No. Franklin Co Rt 1 Gerald St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m  
 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.  
65 11 4  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-19, 1940  
 22. I HEREBY CERTIFY, That I attended deceased from 19... to... 19...  
 I last saw h. alive on... 19... 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:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 13. NAME \_\_\_\_\_  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 15. MAIDEN NAME \_\_\_\_\_  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 17. INFORMANT (ADDRESS) \_\_\_\_\_  
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE, 19...  
 19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_  
 20. FILED 3-8, 1940 Charles A. Schmitt Local Registrar

Other contributory causes of importance: \_\_\_\_\_  
 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) J. W. Merk, M. D.  
Gerald (Address) ms

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

