

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

Dr. Callaway

2347

Do not use this space.

1. PLACE OF DEATH **GREENE**

(a) County **GREENE** Registration District No. **376**

(b) Township **SPRINGFIELD** Primary Registration District No. **200** Registered No. **119**

(c) City **SPRINGFIELD** (d) Street No. **Burge Hospital** St. **119**

(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 **4011 August Adam Mehl**

(a) Residence, No. **803 S. Florence** 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 **Carrie E. Mehl**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept. 18, 1855**

7. AGE YEARS **84** MONTHS **3** DAYS **15** If LESS than 1 day, hrs. or min.

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. **agent**

10. Date deceased last worked at this occupation (month and year) **10/5** **11. Total time (years) spent in this occupation** **10/5**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **unk.**

13. NAME **Adolphus Mehl**

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

15. MAIDEN NAME **Elizabeth Keith**

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

17. INFORMANT (ADDRESS) **Carrie E. Mehl 803 S. Florence, City**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Maple Park** DATE **1-5** 19**40**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Alma Schreyer Springfield, Mo.**

20. FILED **1/5** 19**40** **Chas. E. Gense, Jr. Local Registrar.**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-3** 19**40**

22. I HEREBY CERTIFY, That I attended deceased from 19..... to **Jan 3** 19**40**

I last saw him..... alive on **Jan 2** 19**40** Death is said to have occurred on the date stated above, at **8 A** m.

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

Pneumonia, lobar Date of onset **2/31/39**

Other contributory causes of importance: **10/5**

Name of operation..... **none** 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 **No**

(Signed) **Dr. Callaway** M. D.

(Address) **Springfield 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.

Not Count

1914

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.....

Chas G George

Registered Apprentice No.

204

working under my personal supervision.

Signed.....

E O Worthy

Licensed Embalmer No.

1767

P. O. Address

Springfield

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.

X