FILED APR 15 1941

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

Do not use this space.

11344

1. PLACE OF DEATH
County Maries — Registration District No. 1040 — File No.
Township Miller — Primary Registration District No. 5736 — Registered No. 6
City — (No. , St. Ward)

2. FULL NAME Montgomery Messersmith
(a) Residence, No. (Usual place of abode) St., Ward. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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: Leona Messersmith
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 2-15-1851
7. AGE: Years 90 — Months 1 — Days 8 — If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Farmer
9. Industry or business in which work was done, as silk mill, 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): Missouri

FATHER
13. NAME: Barney Messersmith
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

MOTHER
15. MAIDEN NAME: Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Jessie Messersmith, Dixon Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Wheeler DATE: 3/24 1941
19. UNDERTAKER (ADDRESS): Fred H Gilbert, Dixon Mo.
20. FILED: 3, 25, 1941 C W Winkelman, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): March 23, 1941
22. I HEREBY CERTIFY, That I attended deceased from March 1, 1941, to March 20, 1941
I last saw him alive on March 20, 1941. 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:
Mitral stenosis — Date of onset: unknown
92 B
Other contributory causes of importance:
Decubitus — 3/5/41
Name of operation — Date of —
What test confirmed diagnosis? — 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) Conley Gates M. D.
(Address) Brinktown, Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ...

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11344

Registration District No. 1040 Primary Registration District No. 5736 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Maries

(b) City or town Miller T.P.
(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 Missouri (b) County Maries

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Miller Twp.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Montgomery Messersmith

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W.

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 90 Months 1 Days 8 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 6-14-41 (Date received local registrar) (b) C W Winkelman (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Mar day 23 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Conley Gates (M. D. or other)

Address Brinktown Mo. Date signed

SUPPLEMENTARY

(Licensed Embalmer's Statement on Reverse Side)

1941
S-11344

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.