No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 19 1942

Registration District No. 2

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 6396

Primary Registration District No. 3014

Registrar's No. 33

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

**1. PLACE OF DEATH:**
(a) County: COLE
(b) City or town: JEFFERSON City, MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 19 days (Specify whether years, months or days)
In this community:

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: MO (b) County: OSAGE
(c) City or town: LINN, MO.
(If outside city or town limits, write "RURAL")
(d) Street No.: ()
(If rural, give location)
(e) Citizen of foreign country? (Yes or No): /
If yes, name country:

3. (a) PRINT FULL NAME: WILLIAM MEYERS.
3. (b) If veteran, name war:
3. (c) Social Security No.:

4. Sex: MALE
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: CHRISTENE MEYERS
6. (c) Age of husband or wife if alive: 70 years
7. Birth date of deceased: FEB (Month) 27 (Day) - 1865 (Year)

8. AGE: Years 76 Months 11 Days 7 If less than one day hr. min.

9. Birthplace: OSAGE County MO (City, town, or county) (State or foreign country)
10. Usual occupation: FARMER
11. Industry or business:
FATHER
12. Name: LAWRENCE MEYERS
13. Birthplace: GERMANY (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: ANNA SCHAEFER
15. Birthplace: UNKNOWN (City, town, or county) (State or foreign country)
16. (a) Informant: WALTER MEYERS.
(b) Address: LINN, MO.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-9-42 (Month) (Day) (Year)
(c) Place: burial or cremation: FRANKENSTEIN, MO
18. (a) Signature of funeral director: Clyde Morton
(b) Address: LINN, MO
19. (a) Feb 5-1942 (Date received local registrar) (b) Norma Pickton (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 5th year 1942 hour 6 minute 35 P.M.
21. I hereby certify that I attended the deceased from Jan 25th 1942 to Feb 5th 1942 that I last saw him alive on Feb 5th 1942; and that death occurred on the date and hour stated above.

Immediate cause of death: Lobar Pneumonia — Duration
Due to:
Due to:
Other conditions: Fr. femur. (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: 0 76
(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?
While at work: (Specify type of place) (e) Means of injury:

23. Signature: Thomas J. Kelly M.D. (M. D. or other)
Address: Jefferson City Mo Date signed: Feb 5th 42

(Licensed Embalmer's Statement on Reverse Side)

## 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 John Holt, Registered Apprentice No. 260 working under my personal supervision.

Signed Vernon M. Morton

Licensed Embalmer No. 4125

P. O. Address Lynn

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)**

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

V. S. No. 2B
10M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 6396

Registration District No. 213 Primary Registration District No. 3614 Registrar's No.

**1. PLACE OF DEATH:**
(a) County Cole
(b) City or town Jefferson City
(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 years, months or days)
In this community

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Mertens
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 Feb 27 1866 (Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
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) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month February day
year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Fr Femur | |
| 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? Farm.
While at work? yes (Specify type of place) (e) Means of injury
23. Signature Thomas J. Kelly M.D. (M. D. or other)
Address Jefferson City Mo. Date signed May 14 1942

SUPPLEMENTARY

1866
18