DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4

FILED JAN 10 1944

Registration District No. 09 — Primary Registration District No. 4121 — Registrar's No. 15

1. PLACE OF DEATH:

(a) County Christian

(b) City or town Billings (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 Christian

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

(d) Street No. ____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? 60 yrs. 0 years.

3. (a) PRINT FULL NAME Catherine Mary Mehl

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased Aug (Month) 17 (Day) 1857 (Year)

8. AGE: Years 85 Months 4 Days 12 If less than one day ____ hr. ____ min.

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

10. Usual occupation House wife

11. Industry or business ____

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

MOTHER
14. Maiden name Mary Elizabeth Schreiber
15. Birthplace ____ (City, town, or county) France (State or foreign country)

16. (a) Informant's own signature Theresa Schatz

(b) Address Billings, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN 1. 1944 (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph's Catholic Cem.

18. (a) Signature of funeral director A. G. Wallace

(b) Address Billings Mo

19. (a) DEC. 30, 43 (Date received local registrar) (b) Mary F. Spears (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 year 1943 hour 8 minute 8:30 P M.

21. I hereby certify that I attended the deceased from July 19, 1943, to Dec 29, 1943; that I last saw her alive on Dec 28, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Intestinal obstruction	3 days
Due to large Fibroid tumor of uterus	1
Due to Fracture of neck of left Femur	6 months
Due to Senility	
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 0 days

(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 Charles A Spears (M. D. or other) MD

Address Billings Mo Date signed 12-29

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

RECEIVED
District Health Officer No. 6,
District File Number 144-13
Date Filed 1-6-48

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 me, Registered Apprentice No. Fewr Wallace Funeral Hom working under my personal supervision.

Signed C. T. Lloyd

Licensed Embalmer No. 3527

P. O. Address Bellanza Ill

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan.

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County: Christian
(b) City or town: Billings
(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: Catherine M. Mehl
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Aug. (Month) 17 (Day) 1858 (Year)

8. AGE: Years 85 Months 4 Days ____ Unless less than one day ____ hr. ____ min.

9. Birthplace: ____ (City, town, or county) France (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) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. Day 28 year 1943 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: Intestional obstruction	3 da.
Due to: Large fibroid tumor of uterus	
Due to: Fracture of neck of left femur	6 mo.
Other conditions (Include pregnancy within 3 months of death): Senility	

Major findings:
Of operations: No
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): Accident
(b) Date of occurrence: July 19, 1943
(c) Where did injury occur? Billings (City or town) Christian (County) Missouri (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In yard at home (Specify type of place)
While at work? yes (e) Means of injury: Fell over weeds

23. Signature: Charles A. Spears (M. D. or other) MD
Address ____ Date signed ____

S-41962