

FILED MAR 9 1944/9

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson Mo
(b) City or town Jackson Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: West Hosp. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Lewards
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? RR# 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JAM MEINERSHAGEN

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

4. Sex M 5. Color or race wh 6. (a) Single, widowed, married, divorced M 1

6. (b) Name of husband or wife Verona 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Nov. 6, 1891
(Month) (Day) (Year)

8. AGE: Years 52 Months 3 Days 21 If less than one day hr. _____ min. _____

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

10. Usual occupation farmer

11. Industry or business _____

12. Name Henry Meinershagen

13. Birthplace Pennine Usage Mo
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Stock

15. Birthplace Pennine Usage Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Verona Meinershagen

(b) Address Sevassy Mo

17. (a) Removal Removal (b) Date thereof 3-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Mo

18. (a) Signature of funeral director W. E. Brown

(b) Address Backner Mo

19. (a) 3-27-44 (b) W. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 27
year 44 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him Deputy Coroner _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis of bacterial origin.

Due to _____

Due to _____

Other conditions Ela
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See Above

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? _____

While at work _____ (Specify type of place) Means of injury 0

23. Signature A. E. Warner (M. D. or other) M. D.

Address 221 W. Coy Date signed 3/27/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 _____

working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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, fact should be so stated above.