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DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **37791**  
 Registrar's No. **884**

**FILED NOV 24 1944**  
 Registration District No. **128**

Primary Registration District No. **2000**

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

1. PLACE OF DEATH: **TRENE**  
 (a) County **SPRINGFIELD**  
 (b) City or town **SPRINGFIELD**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **820 N. ROGERS.**  
 (If not in hospital or institution, write street number or location) **1**  
 (d) Length of stay: In hospital or institution **2 DAYS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **ANNA MEINHARDT.**  
 3. (b) If veteran, name war **NONE**  
 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**  
 6. (b) Name of husband or wife **JACOB MEINHARDT** 6. (c) Age of husband or wife if alive **UNK. years 22**  
 7. Birth date of deceased **FEB. 1879**  
 (Month) (Day) (Year)

8. AGE: Years **65** Months **8** Days **15** If less than one day hr. min.

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

10. Usual occupation **House wife**  
 11. Industry or business **at home**

MOTHER FATHER

12. Name **unk.** **unknown**  
 13. Birthplace **unk.** **unknown**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **unk.** **unknown**  
 15. Birthplace **unk.** **unknown**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Sebald Stahl**  
 (b) Address **Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 11-1944**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Willow Springs Mo.**

18. (a) Signature of funeral director **J. W. Klingner**  
 (b) Address **Springfield Mo.**

19. (a) **11-10-44** (b) **J. W. Klingner**  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **MO.** (b) County **Howell 46**  
 (c) City or town **Willow Springs**  
 (If outside city or town limits, write "RURAL") **0**  
 (d) Street No. (If rural, give location)  
 (e) Citizen of foreign country? **yes** (Yes or No)  
 If yes, name country **Germany 1**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Nov.** day **7<sup>th</sup>**  
 year **1944** hour **12** minute **30 A. M.**

21. I hereby certify that I attended the deceased from **10/10** to **11-7**, 19**44**  
 that I last saw **her** alive on **11-7**, 19**44**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Sen. = Carcinoma uterine, with Sen. metastasis**  
 Due to **Sen. metastasis**

Due to **Sen. metastasis**

Other conditions **Fracture femur**  
 (Include pregnancy within 3 months of death)

Major findings: **Cancer infection**  
 Of operations  
 Of autopsy **no**

Duration  
 PHYSICIAN  
 Underline the cause to which death should be charged etiologically.

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? **no** (Specify type of place) (e) Means of injury **✓**

23. Signature **J. W. Klingner** (M. D. or other)  
 Address **Springfield Mo** Date signed **11-7-44**

APR 5 1955

**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..... *Ogle Stone Jr.*

Licensed Embalmer No. *4176*

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, fact should be so stated above.**

X

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. See  
Registrar's No. 854

Registration District No. 128 Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(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

3. (a) PRINT FULL NAME

Anna Meinhardt

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 m

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Feb - 22 - 1888  
(Month) (Day) (Year)

8. AGE:

Years 65

Months 8

Days \_\_\_\_\_

If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

Germany  
(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

(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)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 22 Year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Thigh bone which became unbalanced  
(Include pregnancy within 3 months of death)

Major findings: Cancer of bone  
Of operations none

PHYSICIAN \_\_\_\_\_

Of autopsy no

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) no  
(b) Date of occurrence none  
(c) Where did injury occur? Home Thigh bone cancer broke while (City or town) (County) in court  
(d) Did injury occur in, or about home, on farm, in industrial place, in public place? A

While at work? no (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature D. F. Freeman (M. D. or other) \_\_\_\_\_  
Address Springfield Date signed 2/27/44

SUPPLEMENTARY

37791