

FILED MAR 10 1945

Registration District No. 370

Primary Registration District No. 305-8

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town St. Charles  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 90 days  
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Rosie Mensie (MENSIE)

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 2 Widowed

6. (b) Name of husband or wife Anton Mensie 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 23 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
59 0 8 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House work

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

MOTHER FATHER { 12. Name Steve Reller  
13. Birthplace Lincoln Co Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Hembrock  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clarence Wehde  
(b) Address Old Monroe Mo

17. (a) Burial (b) Date thereof Jan. 3 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Monroe Mo

18. (a) Signature of funeral director C. A. ...

(b) Address Ofallon Mo

19. (a) 1-3-1945 (b) Conrad G. Paul  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Charles  
(c) City or town Old Monroe Mo 92  
(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.? 8 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 31  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 10/27/44  
\_\_\_\_\_ 19\_\_\_\_ to 12/31/44 19\_\_\_\_;  
that I last saw him alive on 12 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

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

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

Other conditions Generalized carcinoma of the  
(Include pregnancy within 3 months of death)

Major findings: general abdominal metastases, Ca of left ovary  
Of operations \_\_\_\_\_  
Of autopsy none

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?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Edwin ... (M. D. or other) MD  
Address St. Charles, Mo Date signed 1/3/45

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

12  
9  
3

RECEIVED  
District Health Officer No. 9,  
District File Number \_\_\_\_\_  
Date Filed 3-9-45

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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 E. A. Keithly  
Licensed Embalmer No. 874  
P. O. Address Fallon Mo

**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.**