—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16869

FILED JUN 15 1948

Registration District No. 781

Primary Registration District No. ~~4294~~ 5677

Registrar's No.

1. PLACE OF DEATH:
(a) County LINCOLN
(b) City or town RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3 Mi S SILEX, MO
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community LIFETIME (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County LINCOLN 57
(c) City or town RURAL 0
(If outside city or town limits, write "RURAL")
(d) Street No. 3 Mi S. SILEX, MO. 0
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME PATRICK FRANCIS MEUTH

3. (b) If veteran, name war NO

3. (c) Social Security No. 486-14-1072

4. Sex MO

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife OSIE MEUTH

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased JUNE (Month) 23 (Day) 1904 (Year)

8. AGE: Years 43 | Months 11 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace SILEX (City, town, or county) MO (State or foreign country) 0

10. Usual occupation MECHANIC

11. Industry or business —

FATHER
12. Name CARL F MEUTH
13. Birthplace SILEX (City, town, or county) MO (State or foreign country) 0

MOTHER
14. Maiden name ARNOL GESSMAN
15. Birthplace GERMANY (City, town, or county) (State or foreign country) 4

16. (a) Informant MRS OSIE MEUTH
(b) Address SILEX, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-8-48 (Month) (Day) (Year)
(c) Place: burial or cremation MILLWOOD, MO.

18. (a) Signature of funeral director J O Mudd
(b) Address Bowling Green, MO.

19. (a) 6-6-48 (Date received local registrar) (b) MRS T A DWYER (Registrar's signature) 164

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5th year 1948 hour 3 PM minute — M.

21. I hereby certify that I attended the deceased from June 4th, 1948 to June 5, 1948 that I last saw him alive on June 5, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Thrombus	
Due to Pleurisy	1 Day
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature R. M. Penn (M. D. ~~or other~~) M. D.
Address Silex Date signed 6-7-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 14 1948

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 Ernest O. Wilson, Registered Apprentice No. 490, working under my personal supervision.

Signed Raymond L. Morris

Licensed Embalmer No. 4330

P. O. Address Vandalia, 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, fact should be so stated above.

No. 2B
M—3.45
P I X43880

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. June

Registration District No. 101 Primary Registration District No. 5677 Registrar's No.

1. PLACE OF DEATH:
(a) County Lincoln
(b) City or town Rural
(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 Patrick F. Meuth
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 June 23 (Month) (Day) 19 (Year)

8. AGE: Years 43 Months 11 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) No (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) 6/6/48 (Date received local registrar) (b) Mrs. T. A. Dwyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 1 year 1944 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.
Immediate cause of death — Duration
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-16869