S. No. 2
M—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41200

FILED DEC 29 1948

Registration District No. 306

Primary Registration District No. ~~60~~ 84453

Registrar's No. 319

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

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Peters
(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 Mo. (b) County St. Charles

(c) City or town O'Fallon
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? mo (Yes or No)

If yes, name country ---------

3. (a) PRINT FULL NAME Lillie Mergenthal

3. (b) If veteran, name war ------

3. (c) Social Security No. ---------

4. Sex F

5. Color or race White

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

6. (b) Name of husband or wife Lawrence Mergenthal

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

7. Birth date of deceased March (Month) 5 (Day) 1875 (Year)

8. AGE: Years 73 Months 9 Days 11 If less than one day ------- hr. ..... min.

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

10. Usual occupation House work

11. Industry or business -------

FATHER
12. Name James Smith
13. Birthplace Lincoln Co. Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Not known
15. Birthplace not known (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edna Meyers

(b) Address St. Peters Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-19-48 (Month) (Day) (Year)

(c) Place: burial or cremation O'Fallon Mo.

18. (a) Signature of funeral director E. A. Keithley

(b) Address O'Fallon Mo.

19. (a) Dec 21-48 (Date received local registrar) (b) E. A. Keithley (Registrar's signature) 280

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 16 year 1948 hour 2 minute P M.

21. I hereby certify that I attended the deceased from Jan 1947, to 16 Dec 1948 that I last saw her alive on 13 Dec 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death chronic myocarditis	10 yrs
Due to gen'l arteriosclerosis	15 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

93 D

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 Lawrence G Behn MD (M. D. or other)

Address O Fallon Mo Date signed 21 Dec 48.

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Distrlot Health Officer No. 9,
District File Number DEC 28 1948
Date Filed

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. 8 & 1

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, fact should be so stated above.