FILED NOV 2 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34470

BIRTH NO. _____ REG. DIST. NO. 309 PRIMARY REG. DIST. NO. 6050 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY St. Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) West Alton
c. LENGTH OF STAY (in this place) 33 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) R.R.#1, West Alton

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY St. Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) West Alton
d. STREET ADDRESS (If rural, give location) R.R. #1

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3. NAME OF DECEASED (Type or Print) a. (First) Benjamin b. (Middle) B. c. (Last) Mennemeier

4. DATE OF DEATH (Month) (Day) (Year) Oct. 29, 1955

5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 20, 1862
9. AGE (In years last birthday) 93 — IF UNDER 1 YEAR: Months 8, Days 9 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Germany 4
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Frank Mennemeier
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Sophie Kampman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME X Mayme I. Hosey, ADDRESS Alton, Ill.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary infarction

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c) Congestive Heart failure

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

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INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-5, 1955, *to* 10-29, 1955, *that I last saw the deceased alive on* 10-28, 1955, *and that death occurred at* 9:50 A m., *from the causes and on the date stated above.*

23a. SIGNATURE P. T. Camus (Degree or title) P.O.
23b. ADDRESS Portage Des Sioux Mo
23c. DATE SIGNED 10-31-55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-1-1955
24c. NAME OF CEMETERY OR CREMATORY Ebenezer
24d. LOCATION (City, town, or county) (State) West Alton, Missouri

DATE REC'D BY LOCAL REG. 11-2-55
REGISTRAR'S SIGNATURE Clyde A. Bridges
25. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Burke Jr. ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 .....

....., Student Embalmer No. .....

working under my personal supervision.

Signed Thomas J. Burke Jr.

Signed .....
Student Embalmer

Licensed Embalmer No. 4968

P. O. Address 727 LANGDON, ALTON

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.