

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Do not use this space.

Dr. Chapman MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH
 County *Miss* Registration District No. *566*
 Township *Jay waffle* Primary Registration District No. *5762*
 City (No. *J.*) St. *117* Ward

2. FULL NAME *Belle Meissner*
 (a) Residence. No. *Charleston* St. *117* Ward. *117*
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

File No. *27939*
 Registered No. *61*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *August Meissner*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 16-1863*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
65 3 16

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *housekeeper*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 3 - 1928*

17. I HEREBY CERTIFY That I attended deceased from *JULY 13, 1928* to *AUG 3, 1928* that I last saw *her* alive on *JULY 8, 1928*, and that death occurred, on the date stated above, at *117* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
CHRONIC DIARRHEA
1209 114 B
 CONTRIBUTORY *NONE KNOWN*
 (SECONDARY) (duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Madison Indiana*

10. NAME OF FATHER *Geo. Bestner*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Indiana*

12. MAIDEN NAME OF MOTHER *Ann Bestner*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Indiana*

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? *NO* DATE OF *1*
 WAS THERE AN AUTOPSY? *NO*
 WHAT TEST CONFIRMED DIAGNOSIS *CLINICAL SYMPTOMS - a. Dr. Chapman*
 (Signed) *Dr. Chapman*, M. D.
 , 19 (Address) *Charleston, Mo.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT *Henry Meissner* +
 (Address) *Charleston Mo. R.F.D. No. 1*

15. *Aug 4th 1928* *F. J. Vernon*
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Oak Grove* DATE OF BURIAL *Aug 4, 1928*

20. UNDERTAKER *Truro Shelby* ADDRESS *East Louis Mo*

