

No. 2  
4-13-40  
-17-39  
X23159

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **9694**  
**1103**  
Registrar's No. \_\_\_\_\_

BUREAU OF THE CENSUS  
**APR 15 1941**  
Registration District No. **399**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:  
(a) County **Jackson,**  
(b) City or town **Kansas City,**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**4605 Holmes Street,**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **no.** (Specify whether  
In this community **50 years,**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED: **48**  
(a) State **Missouri,** (b) County **Jackson, 3**  
(c) City or town **Kansas City, 8**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **4605 Holmes Street, 0**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? **no.** years.

3. (a) PRINT FULL NAME **Mrs. Helena Marie Meinrath,**  
3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **March** day **16th**  
year **1941** hour **2:400** minute **A.** M.

4. Sex **Female /** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Married,**  
6. (b) Name of husband or wife **Joseph Meinrath,** 6. (c) Age of husband or wife if alive **80** years  
7. Birth date of deceased **March 12 1862**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1939** to **March 16 1941**  
that I last saw h. **er** alive on **March 15 1941**  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Pelvic Malignancy** Duration

8. AGE: Years Months Days If less than one day  
**79 0 4** hr. min.

Due to **Metastasis Pelvic Carcinoma**

9. Birthplace **Massachusetts, /**  
(City, town, or county) (State or foreign country)

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

10. Usual occupation **at home,**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business **x**

Major findings: Of operations

12. Name **Herman Susmann,**

Of autopsy

13. Birthplace **Germany, 4**  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

14. Maiden name **Helena Selvers,**

15. Birthplace **Germany, 4**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Irving Meinrath,**

(b) Address **3534 Charlotte, Kansas City, Mo.**

17. (a) **Burial** (b) Date thereof **3-18-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Washington Cemetery**

18. (a) Signature of funeral director **Stine & McClure,**

(b) Address **3235 Gilham Plaza, K. C., Mo.**

19. (a) **3/17/41** (b) **M. M. Crowe**  
(Date received local registrar) (Registrar's signature)

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. M. Crowe** (M. D. or other) **MD**  
Address **1408 Walden Rd** Date signed **3/17/41**

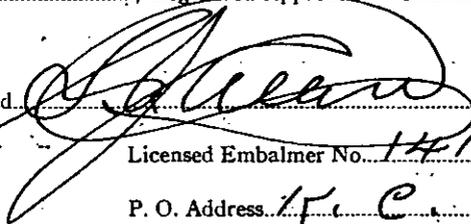
Dr. Ketcham,  
Waldheim Bldg 1-30  
No 6708

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



Licensed Embalmer No. 1415

P. O. Address. H. C. Myo

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.

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STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. **1103**

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

1. PLACE OF DEATH:

(a) County .....  
(b) City or town .....  
(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)

3. (a) PRINT FULL NAME **Mrs. Helena Marie Meinrath**

3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced... **Married**

6. (b) Name of husband or wife ..... 6. (c) Age of husband, or wife, if alive ..... years

7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day ..... min.

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

10. Usual occupation .....

11. Industry or business .....

12. Name .....

13. Birthplace ..... (City, town, or county) (State or foreign country)

14. Maiden name .....

15. Birthplace ..... (City, town, or county) (State or foreign country)

16. (a) Informant .....

(b) Address .....

17. (a) ..... (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation .....

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

(b) Address .....

19. (a) **3/17/41** (b) **M. M. Krowe** (Date received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A.? ..... years.

DEATH CERTIFICATION

20. DATE OF DEATH: Month **March** day **16th** year **1941** hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19 ..... to ..... 19 ..... that I last saw him ..... alive on ..... and that death occurred on the date and hour stated above.

Immediate cause of death: **Pelvic Malignancy**

Due to: **Metastasis pelvic carcinoma**

Due to: **Primary bladder carcinoma**

Other conditions: ..... (Include pregnancy within 3 months of death)

Major findings: Of operations .....

Of autopsy .....

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 ..... (M. D. or other) .....

Address ..... Date signed .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

9694