

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29228

State File No. _____

Registration District No. 765

Primary Registration District No. 6266

Registrar's No. 6

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

1. PLACE OF DEATH: St. Clair
 (a) County St. Clair
 (b) City or town Rural District 122
 (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 4 weeks
 years, months or days

2. USUAL RESIDENCE OF DECEASED: ✓
 (a) State Mo (b) County 999
 (c) City or town _____ (If outside city or town limits, write "RURAL") 25
 (d) Street No. _____ (If rural, give location) 0
 (e) If foreign born, how long in U. S. A? 23 years

3. (a) PRINT FULL NAME GLENN Minert
 3. (b) If veteran, name war NO 3. (c) Social Security No. NO

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 24
 year 1941 hour 8 minute AM
 21. I hereby certify that I attended the deceased from
7 - 4, 1941, to 7 - 24, 1941;
 that I last saw him alive on 7 - 24, 1941;
 and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Alma Minert 6. (c) Age of husband or wife if alive 45 years
 7. Birth date of deceased July 27 - 1891
 (Month) (Day) (Year)

Immediate cause of death Typhoid fever 3 weeks
 Duration

8. AGE: Years 49 Months 11 Days 27 If less than one day
 hr. _____ min. _____

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Eugene Oregon (City, town, or county) (State or foreign country)
 10. Usual occupation Mgr. Fire shop
 11. Industry or business _____
 12. Name B. F. Minert
 13. Birthplace Unknown (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____ (City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 16. (a) Informant Mrs. Alma Minert
 (b) Address Melton Mo.
 17. (a) Campport Mo. (b) Date thereof July 28 - 41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Melton Mo.
 18. (a) Signature of funeral director W. H. Miller
 (b) Address Becker Mo.
 19. (a) 9 - 9 - 1941 (b) W. H. Miller
 (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 T. H. Dangler, Jr. (M. D. or other) M.D.
 Address Osceola, Mo. Date signed 7-24-41

RECEIVED

District Health Officer No. 7,

District File Number 9-41-1678

Date Filed 9-15-41

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..... *C. S. Kelly*

Licensed Embalmer No. 2097

P. O. Address..... *Essex*

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.

STANDARD CERTIFICATE OF DEATH

State File No. 29228

Registration District No. 765

Primary Registration District No. 6266

Registrar's No.

1. PLACE OF DEATH:

(a) County St Clair

(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)
In this community 4 weeks years, months or days

3. (a) PRINT FULL NAME Glenn Dainert

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 July 27 1899
(Month) (Day) (Year)

8. AGE: Years 49 Months 11 Days 14 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 10-16-41 (b) Paul H. Seavers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Nebraska (b) County _____

(c) City or town Nelson
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I have seen him/her 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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

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

SUPPLEMENTARY

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

Mo.

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