

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

12315

Registration District No. \_\_\_\_\_

Primary Registration District No. 6174

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Warren  
(b) City or town Marthasville R.R. Warrenton Mo.  
(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 at home (Specify whether \_\_\_\_\_)  
In this community all his life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Warren  
(c) City or town Marthasville R.R. Mo.  
(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.: Born in U.S. years.

3. (a) PRINT FULL NAME HERMAN FRANKLIN MINNING

3. (b) If veteran, name war no veteran of war 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married  
6. (b) Name of ~~husband~~ or wife Mary Ann Minning 6. (c) Age of husband or wife if alive 57 years  
7. Birth date of deceased Apr 25 (Month) (Day) (Year) 1885

8. AGE: Years 62 Months 10 Days 27 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business Acorn

MOTHER FATHER  
12. Name August Minning  
13. Birthplace Warren Co Mo (City, town, or county) (State or foreign country)  
14. Maiden name Farmer Welch  
15. Birthplace Warren Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Minning  
(b) Address Marthasville R.R. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-42 (Month) (Day) (Year)  
(c) Place: burial or cremation Wright City Cem.

18. (a) Signature of funeral director Wright City Cem.  
(b) Address Wright City Mo.

19. (a) 3/23/42 (Date received local registrar) (b) Julius Nieburg (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 22 year 1942 hour 9 minute 40 A. M.

21. I hereby certify that I attended the deceased from Dec 1st, 1941, to Mar 22nd, 1942, that I last saw him alive on Mar 6th, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Acute parenchymatous nephritis Duration 3 months

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

Other conditions Heart disease, pyorrhea  
(Include pregnancy within 5 months of death) infected teeth, high blood pressure

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy No autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? None (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 None

23. Signature Benjamin Brandt (M. D. or other) \_\_\_\_\_

Address Loristall Mo. Date signed 3-22-42

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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, *JK*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Julius J. Neberg*

Licensed Embalmer No. *3366*

P. O. Address *Wright City*

**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, above space should be left blank.**

STANDARD CERTIFICATE OF DEATH

State File No. 12315

Registration District No. 882

Primary Registration District No. 6174

Registrar's No.

1. PLACE OF DEATH

(a) County Warren  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

Herman F. Minning

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 apr. 25  
(Month) (Day) (Year)

8. AGE: Years 62 Months - Days 20  
(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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar day 22  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; \_\_\_\_\_ 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to ephratitis

Due to Pinches and infected teeth started as acute ephritis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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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 Benjamin Praydt (M. D. or other) \_\_\_\_\_

Address Forstall & Co Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-12315 1942