

FILED MAY 9 1944

State File No. 32

Registration District No. 8944

Primary Registration District No. 5304A

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Cole
 (b) City or town Rural near St. Thomas, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Rural / 1000 1/2 mi W
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 50 yrs
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole
 (c) City or town Nearer St Thomas, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. Rural Nearer St. Thomas, Mo.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Christine Boessen

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

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

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

7. Birth date of deceased October 22 1853
St. Thomas, Mo.
 (Month) (Day) (Year)

8. AGE: Years 90 Months 5 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Frank Lavan

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

14. Maiden name Margaret Coenen

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

16. (a) Informant Mrs Bertha Meyerpeter

(b) Address St. Thomas, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/44
 (Month) (Day) (Year)

(c) Place: burial or cremation St. Thomas, Mo. Cem.

18. (a) Signature of funeral director Victor Buesche

(b) Address Jaffars on City, Mo.

19. (a) 4/12/44 (Date received local registrar) (b) Dr. Wm. E. Gering
By [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
 year 1944 hour 10 minute _____ A. M.

21. I hereby certify that I attended the deceased from April 1st 1944 to April 9 1944
 that I last saw her alive on April 19 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Pneumonia 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 Henry G. Scribner (M. D. or other) _____

Address Meta, Mo. Date signed 4/11/44

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 5-8-4

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 Victor Buesche

Licensed Embalmer No. 3701

P. O. Address Jafferson City, Mo

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.

Registration District No. 81

Primary Registration District No. 5304A

1. PLACE OF DEATH:

(a) County Cola

(b) City or town Rural - Osage Imp.
(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 years, months or days)

3. (a) PRINT FULL NAME Christine Beersen

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex F

5. Color or race w

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife.....

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

7. Birth date of deceased Oct 22 1902
(Month) (Day) (Year)

8. AGE: Years 90 Months 6 Days 10 If less than one day..... min.

9. Birthplace Mo.
(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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) (Date received local registrar) (b) (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 Jan year 1944 hour 10 minute 30 M.

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

Immediate cause of death myocarditis pneumonia

Due to Bronco-Pneumonia

Due to.....

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

Major findings: 9301

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.....

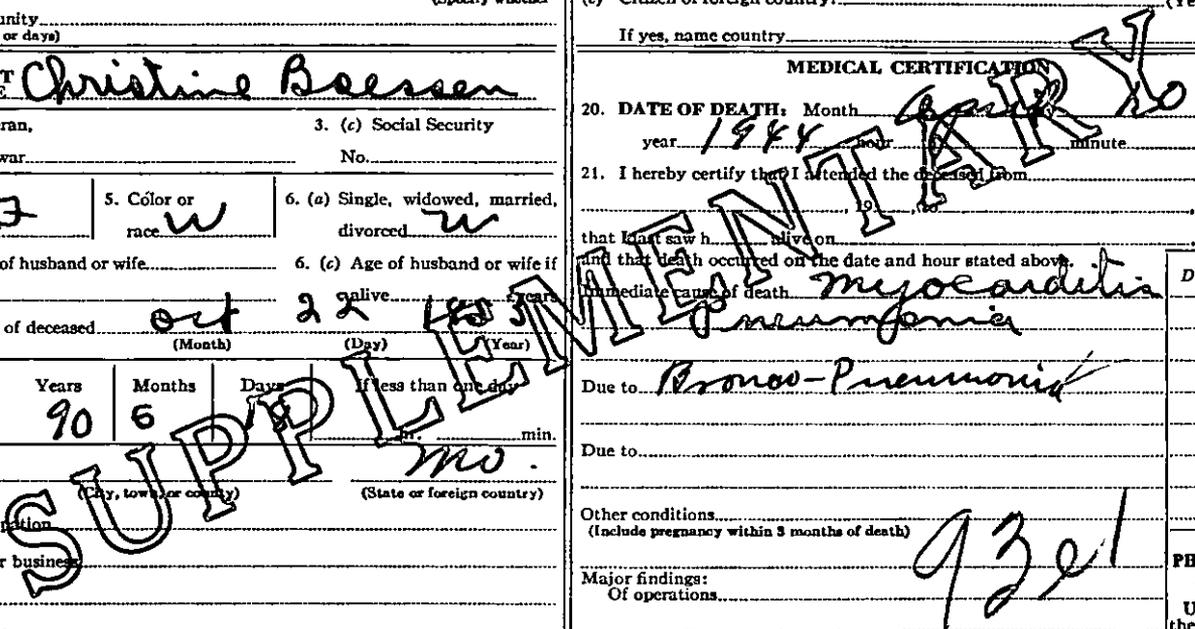
(c) Where did injury occur?..... (City or town) (County) (State)

(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 Henry B. Leuberg (M. D. or other).....

Address Meta Mo Date signed 5-13-44



USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

14472

#1 St. Joensberg
meta, p. 100