

FILED AUG 14 1944

State File No.

Registration District No. 236

Primary Registration District No. 4497

Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon, Winona
(b) City or town Winona
(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 8 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Shannon
(c) City or town Winona
(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 no

3. (a) PRINT FULL NAME James Paul Meng

3. (b) If veteran, name war World War 1 3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bessie Cutts 6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased May 7 1897
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>2</u>	<u>20</u>	hr. min.

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

10. Usual occupation Store Manager

11. Industry or business

MOTHER FATHER { 12. Name Oscar L. Meng
13. Birthplace Calloway Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Maggie Gatheright
15. Birthplace Henry Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bessie Meng
(b) Address Winona, Mo.
17. (a) Burial (b) Date thereof 7-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Munsell Chapel
18. (a) Signature of funeral director Phil A. Leuckel
(b) Address Van Buren Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27
year 1944 hour 8 minute 30 P.M.

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

Immediate cause of death Electrocution
Due to contact with high voltage wire
Due to

Other conditions (Include pregnancy within 3 months of death) 1931

Major findings: Of operations 99
Of autopsy none

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 7-27-44
(c) Where did injury occur? Winona Shannon Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place
(Specify type of place)
While at work? no (e) Means of injury Dunns

23. Signature N.T. Rudy (M. D. or other)
Address Winona Mo. Date signed 7/28/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 844442

Date Filed 8-12-44

AUG 16 1944

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 1-27-

Registered Apprentice No. _____

working under my personal supervision.

Signed

Philip A. Leuche

Licensed Embalmer No. 2931

P. O. Address Van Buren

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12 1944
Aug

Registration District No. 326

Primary Registration District No. 4494

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Wrensia
(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

James Paul Meng

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 May 7 1944
(Month) (Day) (Year)

8. AGE: Years 47 Months 2 Days _____ 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 _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 8-9-44 (b) Frank Byde MD
(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 _____ year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him 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)
(c) Means of injury _____

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

MOTHER FATHER

SUPPLEMENTARY

APR 19 1947

25882