

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

2
43
39
36671

FILED NOV 22 1944
Registration District No. 39A

Primary Registration District No. 4038

State File No. _____
Registrar's No. 44

1. PLACE OF DEATH:

(a) County Benton

(b) City or town Warsaw
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
County Jail
(If not in hospital or institution, write street number or location) 3

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 3 yrs 11 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Benton 8

(c) City or town Warsaw 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. County Jail
(If rural, give location)

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

3. (a) PRINT FULL NAME Louis J. Miesner

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

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased Feb. 4. 1896
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1
year 1944 hour 3 minute 40 P.M.

21. I hereby certify that I attended the deceased from _____, 19____ to Nov 1st, 1944
that I last saw him alive on 11-1-, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Sun shot wounds
3 pulled in the back from machine gun
in the hands of (Buster) Goff. Duration _____

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

48 8 27 _____ hr. _____ min.

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

10. Usual occupation Sheriff

11. Industry or business _____

Due to _____

Due to _____

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Herman Miesner

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

14. Maiden name Annie Gerdtz

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

16. (a) Informant Rudolph Miesner

(b) Address Cole Camp, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5. 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Moness Cemetery

18. (a) Signature of funeral director White - Reser

(b) Address Warsaw, Missouri

19. (a) Nov. 7. 1944 (Date received local registrar) (b) Jas. A. Logan (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?

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

23. Signature Walter H. Co. Coroner (M. D. or other) _____
Address Warsaw, Mo. Date signed 11/2/44

65

NOV 28 1944

Officer No. 7,
Dis. No. Number 10-44-1301
Date Filed 11-21-44

DEC 7 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Paul Richard Brewer

Licensed Embalmer No. 4324

P. O. Address. Warsaw, Mo.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec
Registrar's No. KY

Registration District No. 30 Primary Registration District No. 4038

1. PLACE OF DEATH:
(a) County Benton
(b) City or town Warsaw
(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 Louis J. Miesner
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 S

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

7. Birth date of deceased Feb. 4 1909
(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 _____
(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 July day _____ year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death murder shot in back 3 times with machine gun in his home

Due to _____
Due to _____ 166
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY EXAMINATION NEEDED

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) murder
(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? at home
While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature H. E. Hart - Co. Coroner (M. D. or other) _____
Address Warsaw Mo. Date signed _____

SUPPLEMENTARY

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

1944
S-37099

MAN 72 1944