

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF HEALTH OF THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED AUG 29 1946 STANDARD CERTIFICATE OF DEATH

28884
State File No. _____
Registrar's No. **7347**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Barnes Hospital, 0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Warren** **109**
(c) City or town **Warrenton**
(If outside city or town limits, write "RURAL") **1**
(d) Street No. _____ (If rural, give location) **N.R.O**
(e) Citizen of foreign country? _____ (Yes or No) **1**
If yes, name country _____

3. (a) PRINT FULL NAME **RAYMOND ALBERT MEINE**
3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mattie Meine** 6. (c) Age of husband or wife if alive **34** years
7. Birth date of deceased **December 9 1909**
(Month) (Day) (Year)

8. AGE: Years **36** Months **8** Days **13** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER

12. Name **Fred C. Meine**
13. Birthplace **Warren Co. Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Landwehr**
15. Birthplace **Warren Co. Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mattie Meine**
(b) Address **Warrenton, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **8-24-46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Warrenton, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.**

19. (a) **AUG 23 1946** (Date received local registrar) (b) **J. F. Bredeck** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **22**
year **1946** hour **11** minute **30 A.M.**
21. I hereby certify that I attended the deceased from **Aug 17**, 19 **46** to **Aug 22**, 19 **46**.
that I last saw him alive on **Aug 22**, 19 **46**.
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Poliomyelitis**
Due to _____
Due to **2-36**
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy **None**
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 **0**
23. Signature **J. H. Madley** (M. D. or other) **0**
Barnes Hospital Address _____ Date signed **8/22/46**

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

OCT 8 1952

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..... *J. W. Wilkerson*
..... Licensed Embalmer No. *3575*
..... P. O. Address.....

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.