

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 13 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15522

Do not use this space.

1. PLACE OF DEATH

(a) County Moniteau
(b) Township Walker
(c) City

Registration District No. 571
Primary Registration District No. 5769

Registered No. 23

(d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. _____
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>August Beisenmeier</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 17 - 1865</u>		
7. AGE <u>73</u> YEARS	<u>5</u> MONTHS	<u>24</u> DAYS
If LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
11. Total time (years) spent in this occupation		

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>
	13. NAME <u>Moritz Marx</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>
	15. MAIDEN NAME <u>Dorothy Brand</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>
17. INFORMANT (ADDRESS) <u>Kustav Beisenmeier</u> <u>California</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Salem Evangelical</u> DATE <u>4-14-40</u>	
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>William F. Freckmeier</u> <u>California</u>	
20. FILED <u>4-12-40</u> <u>H.R. Popejoy</u> Local Registrar	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 11, 1940
22. I HEREBY CERTIFY, That I attended deceased from April 8, 1940, to April 11, 1940
I last saw her alive on April 11, 1940. Death is said to have occurred on the date stated above, at 3 P. m.
The principal cause of death and related causes of importance were as follows:

Lobar PneumoniaDate of onset
4-8-40

Other contributory causes of importance:

Cardio-vascular disease
with hypertension
Paralysis agitans.

1936.
1932

Name of operation none Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Edgar A. Tibbe, M. D.
504 (Address) California

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.....

H. E. Friedmeyer

Licensed Embalmer No. *2854*

P. O. Address *California 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 15-322

Registration District No. 571

Primary Registration District No. 3769

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town Warner
(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

Louise Marie Bieschmeier

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced and
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased Oct 17 1862
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 24 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation House work
11. Industry or business House work
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) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

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) If foreign born, how long in U. S. A. ? years

20. DATE OF DEATH Month Apr day 11 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy
Duration
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) (a) Means of injury
23. Signature Edgar A. Kibler (M. D. or other)
Address California Date signed

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

ROWENING MOOKAL

