

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.

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

PLACE OF DEATH
County Gasconade
Township Bauef
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 306
Primary Registration District No. 5424

File No. 33923
Registered No. 5

FULL NAME Meina Wilhelmina Kehmhuener (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE widowed
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH June 3, 1827
(Month) (Day) (Year)

AGE 83 yrs. 5 mos. 14 ds. If LESS than
1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Hauserinfe
(b) General nature of industry, business, or establishment in which employed (or employer) Heil-Hauserworks

BIRTHPLACE
(City or town, State or foreign country) Scheman Germany

PARENTS
NAME OF FATHER Unknown
BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown
MAIDEN NAME OF MOTHER Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Kehmhuener
(ADDRESS) 29 1/2 S. 1st St. Mo.

Filed Nov. 19, 1910.
Dr. F. J. Pedersen Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 17, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 16th, 1910, to Nov. 17th, 1910,
that I last saw her alive on Nov. 16th, 1910,
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia
10717
16.2

(Duration) ____ yrs. ____ mos. 4 ds.
Contributory Severe debility
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Dr. John Engelbrecht M. D.
Nov. 19, 1910. (Address) Stony Hill Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted if not at place of death? At place of death.
Former or usual residence Bauef Twp - Drake Mo.

PLACE OF BURIAL OR REMOVAL Co. St. Jacobi ch. Cem DATE OF BURIAL Nov. 20, 1910
UNDERTAKER Wm Kehmhuener ADDRESS Drake Mo.