

ISOLATION HOSPITAL  
AUG 11 1939

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

24346  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. **791**  
 (b) Township ..... Primary Registration District No. **1008**  
 (c) City St. Louis, Mo (d) Street No. 5600 ARSENAL - Isolation Hosp. Bldg.  
 (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME EUGENE MEIER 600

(a) Residence, No. 214 NELLIE St. WR LEMAY, Mo.  
 (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 MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) SEPT 26 - 1923

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
16 10 0

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. STUDENT  
 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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

FATHER 13. NAME EDWARD MEIER

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS

MOTHER 15. MAIDEN NAME EDNA BRINKMEIER

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS

17. INFORMANT (ADDRESS) A. LANE (A. Lane)  
5600 ARSENAL

18. BURIAL, CREMATION, OR REMOVAL PLACE SUNSET BURIAL PK DATE JULY 31 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Hoffmeyer, 11-12  
7814 So. BROADWAY, ST. LOUIS, MO.

20. FILED 28 1939 J. F. Bredest  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 26 1939

22. I HEREBY CERTIFY, That I attended deceased from July 20, 1939, to July 26, 1939.

I last saw him alive on July 26, 1939. Death is said to have occurred on the date stated above, at 9:25 p.m.

The principal cause of death and related causes of importance were as follows:

Staphylococci  
Septicemia

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....  
 What test confirmed diagnosis? H. Cult Was there an autopsy? yes

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 None  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
 If so, specify .....  
 (Signed) Geo. L. Brasler, M. D.  
 (Address) .....

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.

WHILE EXHIBIT, WITH OBTAINING INK—THIS IS A PERMANENT RECORD

276

STATE  
OFFICE

STATEMENT

STATEMENT  
OF WORK

STATE  
OFFICE

**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 *James C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S Broadway*

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

24346  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791  
(b) Township St. Louis Primary Registration District No. 1003 Registered No. 6619  
(c) City St. Louis (d) Street No. .... St.  
(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 Eugene Meier

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
16 10 0

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.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 11-1 19 39 J.F. Bredeck  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-26-39

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. .... alive on ....., 19... Death is said to have occurred on the date stated above, at ..... m. The principal cause of death and related causes of importance were as follows:

Staphylococcus  
Sepsis  
acute arthritis  
cause unknown  
Other contributory causes of importance:  
purulent left hip  
non-traumatic

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....

If so, specify .....

(Signed) Wes L. Boyalyn M. D.

(Address) St. Louis Hospital

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

