

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

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.

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County 1
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(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 Meyer, Laura M.
8. (b) If veteran, name war _____ 8. (c) Social Security No. 687

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MARTIN 6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased AUG 25 1890
(Month) (Day) (Year)

8. AGE: Years 49 Months 2 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace DYERSVILLE IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____
MOTHER FATHER { 12. Name PETER MEYER
18. Birthplace GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature MARTIN MEYER
(b) Address DUBUQUE, IOWA
17. (a) Removal (b) Date thereof 11/5/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dubuque, Iowa.

18. (a) Signature of funeral director Albert H. Hoppe.
(b) Address 4700 Washington Ave.
19. (a) Nov 8 1939 (b) J. F. Bredeck
(Date of local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County 2
(c) City or town Dubuque NR
(If outside city or town limits, write "RURAL")
(d) Street No. 530 East 22nd.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 4
year 1939 hour 11 minute 40 A.M.
21. I hereby certify that I attended the deceased from October 19, 1939, to November 4, 1939;
that I last saw her alive on November 4, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lung, left
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) (e) Means of injury _____
23. Signature J. Fischer (M. D. or other)
Address BARNES HOSPITAL Date signed _____

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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.....

Albert W. Harper

Licensed Embalmer No. 1861

P. O. Address 4700 Washington

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.