S. No. 2
—11-10-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

11-1 34 7-8

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

17040

State File No.

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 4518

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: 3719 Keokuk 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 42 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")

(d) Street No. 2331 S. Broadway
(If rural, give location)

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

3. (a) PRINT FULL NAME August Meyer 600

3. (b) If veteran, Spanish Amer. War.

3. (c) Social Security No. ---

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jane

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased July (Month) 28, (Day) 1865 (Year)

8. AGE: Years 74 Months 9 Days 22 If less than one day hr. min.

9. Birthplace Cincinnati (City, town, or county) Ohio (State or foreign country) 1

10. Usual occupation Retired

11. Industry or business 9

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant X Jane Meyers
(b) Address 3719 Keokuk

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/40 (Month) (Day) (Year)
(c) Place: burial or cremation Sunset

18. (a) Signature of funeral director Wacker-Helderle
(b) Address 2331 S. Broadway

19. (a) MAY 22 1940 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 19 day May
year 1940 hour 8 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 1, 1940, to May 19, 1940;
that I last saw him alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Myocarditis Chronic Acute Uremia caused

Due to by chr myocarditis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 93 C

Of autopsy no

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?
(Specify type of place)
While at work? (e) Means of injury 1

23. Signature Charles C Drace (M. D. or other)
Address 3702 Gravois Date signed 5/20

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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, above space should be left blank.