DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37063

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 9336

FILED DEC 11 1940

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: Alexian Brothers Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

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

(d) Street No. 731 Willmington Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Robert J. Meyers

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Louise

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased Dec. (Month) 25 (Day) 1886 (Year)

8. AGE: Years 53 Months 10 Days 13 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Electrician

11. Industry or business City Of St. Louis

FATHER
12. Name Samuel Meyers
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

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

16. (a) Informant's own signature Louise Meyers
(b) Address 731 Willmington Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11-40 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cem.

18. (a) Signature of funeral director Wm Schumacher
(b) Address 3013 Meramec St.

19. (a) NOV 13 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7th. year 1940 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Nov 1st 1940, 19 , to Nov 7th, 1940 that I last saw him alive on Nov 7th, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Generalized Peritonitis	11/1/40
Carcinoma colon	11/1/40
Due to Pleural Effusion	11/1/40
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Generalized Peritonitis
Of operations Carcinoma Colon
Of autopsy

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

23. Signature William F. McNamara (M. D. or other) M.D.
Address 5923 Virginia Date signed 11/9/40

(Licensed Embalmer's Statement on Reverse Side)

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.

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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 Clarence Kochow, Registered Apprentice No. ....., working under my personal supervision.

Signed Clarence Kochow

Licensed Embalmer No. 3093

P. O. Address 3013 Meramec

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.