

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 1002

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

1. PLACE OF DEATH: **GREENE**

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days
(Specify whether _____)

In this community _____
years, months or days 1

3. (a) PRINT FULLNAME George Meier

3. (b) If veteran, name war No

3. (c) Social Security No. 491-10-3031

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Marie Meier

6. (c) Age of husband or wife if alive Dec. 1879

7. Birth date of deceased: March 12 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>9</u>	<u>1</u>	hr. _____ min.

9. Birthplace Atchison Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Resort Operator

11. Industry or business _____

MOTHER FATHER { 12. Name Alfred Meier

13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Carolyn Wallburger

15. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Oscar W. Meier

(b) Address Springfield, Mo.

17. (a) Removal (b) Date thereof Dec. 13 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 12-13-40 (b) W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone

(c) City or town Galena Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Route # 3 Galena, Mo.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 13
year 1940 hour 2:25 minute A M.

21. I hereby certify that I attended the deceased from 12/10
1940 to 12/13 1940

that I last saw him alive on 12/12 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: (1) Gastric Hemorrhage 3 days
(2) Cerebral Edema or Hemorrhage 1 "

Due to moderate to gastric ulcer
no malignancy

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

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? _____

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

23. Signature Stafawicz (M. D. or other) _____

Address Medical Arts Bldg. Date signed 12/13/40

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, fact should be so stated above.

X