

WHILE I REMAIN CASE CARRYING BACK 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. 791

Primary Registration District No. 1003

Registrar's No.

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:
Park Lane Hospital.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 Days.
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Lulu Meier.
 3. (b) If veteran, name war No.
 3. (c) Social Security No. None.

4. Sex Female. 5. Color or race White. 6. (a) Single, widowed, married, divorced, Married.
 6. (b) Name of husband or wife Ben Meier. 6. (c) Age of husband or wife if alive 66 years
 7. Birth date of deceased October 11 1875.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>4</u>	<u>11</u>	hr. _____ min. _____

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

10. Usual occupation Housewife.

11. Industry or business _____

MOTHER FATHER
 12. Name Fred Wolf.
 13. Birthplace St. Louis, Missouri.
(City, town, or county) (State or foreign country)
 14. Maiden name Caroline Kentz.
 15. Birthplace New Orleans, La.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ben Meier.
 (b) Address 1931 Hebert St.

17. (a) Burial (b) Date thereof 2-15-41.
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Matthews cem.

18. (a) Signature of funeral director Hy. Leidner Und. Co.
 (b) Address 2223 St. Louis Ave.

19. (a) FEB 14 1941 (b) J. W. Breaker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri. (b) County NO.
 (c) City or town St. Louis. 1126
(If outside city or town limits, write "RURAL")
 (d) Street No. 1931 Hebert St. 9
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 12
 year 41 hour 8:50 minute P. M.
 21. I hereby certify that I attended the deceased from 2-2-41
 _____, 19____, to 2-12-41, 19____.
 that I last saw her alive on 2-12-41
 and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Intestinal
Obstruction due to
Due to Adhesions
Large Ventral Hernia
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations Ad P.O.
 Of autopsy see em gut abt

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 Frank J. Sweeney M.D. or other MD
 Address 4930 Ardell Date signed 2-13-41

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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 Domestica Bonder

Licensed Embalmer No. 3367

P. O. Address 7223 St Louis Ave

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.