DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 14 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41599

Registration District No. 275 | Primary Registration District No. 3053 | Registrar's No. 138

1. PLACE OF DEATH:

(a) County: Phelps

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

(c) Name of hospital or institution: McFarland Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12/3/42 - 12/16/42 (Specify whether years, months or days)

In this community: 4 yr -

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Marion 63

(c) City or town: Highgate, Mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Alexander Meyer

3. (b) If veteran, name war: None

3. (c) Social Security No.

4. Sex: M

5. Color or race: W.

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

6. (b) Name of husband or wife: None

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

7. Birth date of deceased: Jan. 12 1861 (Month) (Day) (Year)

8. AGE: 81 Years | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace: State of Indiana (City, town, or county) (State or foreign country)

10. Usual occupation: farming

11. Industry or business:

FATHER
12. Name: Fred Meyer
13. Birthplace: Do not know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Do not know
15. Birthplace: Do not know (City, town, or county) (State or foreign country)

16. (a) Informant: Albert Wille - nephew
(b) Address: Safe, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-18-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Howard Cemetery Gasc. Co.

18. (a) Signature of funeral director: Null & Son
(b) Address: Rolla Mo

19. (a) 12/16/42 (Date received local registrar) (b) Ellis Meeker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16th year 42 hour 12:55 minute P. M.

21. I hereby certify that I attended the deceased from Dec. 3, 1942 to Dec. 16, 1942 that I last saw him alive on Dec. 16 - 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Rupture of old letter	
Due to: Fracture of rt hip (Trocanteric)	
Due to: Fall.	
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: 065

(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: [illegible] (M. D. or other)

Address: Rolla Mo. Date signed 12-16-4

(Licensed Embalmer's Statement on Reverse Side)

10921

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

1
2
2

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
—8-21-41
I X29288

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

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STANDARD CERTIFICATE OF DEATH

State File No. 41599

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 138

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Phelps

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

(c) Name of hospital or institution:
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Alexander Meyer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 12 (Day) 1861 (Year)

8. AGE: Years 81 Months 11 Days 4 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16
year 1942 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions Senility & shock (Include pregnancy within 3 months of death)	
Major findings: Of operations 186a	
Of autopsy 18	

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) accident
(b) Date of occurrence December 2, 1942
(c) Where did injury occur? Home of Austin Harrison, Highgate Mo (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? on farm Inlt (Specify type of place)
While at work? Picking up (c) Means of injury trocanteric hip fracture

23. Signature A. J. McFarland (M. D. or other)
Address Date signed