

FILED MAY 8 1943

Registration District No. 109

Primary Registration District No. 5536

Registrar's No. 35

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

1. PLACE OF DEATH:

(a) County Holt Co

(b) City or town Holt Rural in limits

(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 life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt

(c) City or town Rural Rt 3 (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 Solomon Adolph Meyer

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 28 year 1943 hour 11:30 minute P. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, widower

6. (b) Name of husband or wife Elizabeth R. Meyer 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 3 12 1870 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr. 28 1943, to \_\_\_\_\_ 19\_\_\_\_; that I last saw him alive on Apr. 28 1943; and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 1 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death ASTHMA, PULMONARY Duration 15 yrs.

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

10. Usual occupation farmer

Other conditions CHRONIC MYOCARDITIS (Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

12. Name George Meyer

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

14. Maiden name Mary Ann Kinkel

15. Birthplace Holt Co Mo (City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Charles Triser (b) Address Oregon Mo

17. (a) Oregon (b) Date thereof 5-1-1943 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oregon Mo

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? \_\_\_\_\_

18. (a) Signature of funeral director Bob L. Gable

(b) Address St Joseph - Mo

19. (a) 5-1-43 (b) Pauline Dawson (Date received local registers) (Registrar's signature)

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

23. Signature Howard E. Colman (M. D. or other) D.O.

Address Forest City Mo. Date signed Apr. 29.

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

working under my personal supervision.

Registered Apprentice No.

Signed

*Robert H. Gable*

Licensed Embalmer No.

*3308*

P. O. Address

*St. Joseph, Mo.*

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.