

FILED JUL 10 1943

Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **190**

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

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Galton
(c) Name of hospital or institution State Hospital No. 1
(If not in hospital or institution, write street number or location) 2nd
(d) Length of stay: In hospital or institution 7m (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Saline 14
(c) City or town Malta Bend (If outside city or town limits, write "RURAL") 1
(d) Street No. (If rural, give location) 2
(e) Citizen of foreign country? (Yes or No) D
If yes, name country D

3. (a) PRINT FULL NAME James M. Meier
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 14
year 1943 hour 4 45 minute P M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive _____ years (Day) (Year)
7. Birth date of deceased Aug 5 1869 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6/9/43 to 6/14/43 1943
that I last saw him alive on 6/14/43 and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 10 Days 9 If less than one day _____ hr. _____ min.

Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis

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

Due to 83a
Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Farmer

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business _____
12. Name August Meier
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Mary Miller
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Record
(b) Address _____

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? _____

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof June 15 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Marshall, Mo.
18. (a) Signature of funeral director Don Short
(b) Address Marshall, Mo.

While at work? (Specify type of place) _____
23. Signature George W. Reuss (M. D. or other) M.D.
Address Quilwh Mo Date signed 6/14/43

19. (a) June 15 1943 (Date received local registrar) (b) Josie Mouskoff (Registrar's signature)

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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.....

Donald W. Sheet

Licensed Embalmer No.....

3757

P. O. Address.....

Marshall 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.