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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26121

FILED JUL 17 1943

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1620

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6454 San Bonita
(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 Missouri (b) County St. Louis 96 2
(c) City or town Clayton 3
(If outside city or town limits, write "RURAL")
(d) Street No. 6454 San Bonita
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME LOUIS PHILLIP MEYERSON

3. (b) If veteran, name war .....

3. (c) Social Security No. 494-05-6269

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Sarah Meyerson

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased July (Month) 17 (Day) 1873 (Year)

8. AGE: Years 69 Months 11 Days 27 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Germany 4 (State or foreign country)

10. Usual occupation Technician

11. Industry or business Testing Laboratory

FATHER
12. Name unknown
13. Birthplace ..... (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace ..... (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Sarah Meyerson
(b) Address 6454 San Bonita

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul. 16-43 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director Herman Reidskopf
(b) Address 5216 Delmar

19. (a) JUL 16 1943 (Date received local registrar) (b) C. G. McTarnon M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14th year 1943 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from JUNE 1939, 1939, to JULY 14th, 1943, that I last saw him alive on JULY 14th, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC MYOCARDITIS

Due to ARTERIO SCLEROSIS ET HYPERTENSION

Due to .....

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

Major findings:
Of operations .....
Of autopsy .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature J. A. Hartmann M.D. (M. D. or other)
Address 602 CENTURY BLDG Date signed 7-14-43

(Licensed Embalmer's Statement on Reverse Side)

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 Chas. W. Cooper

Licensed Embalmer No. 3830

P. O. Address 5216 Delmar

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.