

S. No. 2
DM-2-43
5-17-39
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

30205

State File No. _____

FILED OCT 2 - 1943

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **8489**

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None 2587^a Warren
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community _____ years, months (or days)

3. (a) PRINT FULL NAME August Meyer

3. (b) If veteran, name war None 3. (c) Social Security No. 493-05-4355

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Amanda 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased 10 18 75
(Month) (Day) (Year)

8. AGE: Years 67 Months 11 Days 5 If less than one day hr. min.

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

10. Usual occupation Labor

11. Industry or business Construction

MOTHER FATHER { 12. Name August Meyer

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

14. Maiden name Unknown

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

16. (a) Informant Amanda Meyer

(b) Address 2587 A Warren

17. (a) Burial (b) Date thereof Sept 27 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fridens

18. (a) Signature of funeral director Provost Mortuary

(b) Address 3710 N Grand

19. (a) SEP 25 1943 (b) J. J. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St Louis 20
(If outside city or town limits, write "RURAL")
(d) Street No. 2587 A Warren 100
(If rural, give location) 1-7
(e) Citizen of foreign country? No (Yes or No) 9
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23
year 1943 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from June 28, 1943, to Sept 23, 1943; that I last saw him alive on Sept 23, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma (lower third of esophagus)

Due to _____
Due to _____

Other conditions 4/6
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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)
(2) Means of injury _____

23. Signature William H. Grundmann (M. D. or other) M.D.
Address 2519 N. Jefferson Date signed 9/27/43

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

Duration about 6 months?
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 L. Brinkman

Licensed Embalmer No. *35523*

P. O. Address *3710 N Grand*

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.