

FILED SEP 20 1943

Registration District No. **149** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
3229 E 9th St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 1 Year years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 3229 E 9th St
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jacob E. Meyer

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife H. Sanders E.

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

7. Birth date of deceased: 1913
(Month) (Day) (Year)

8. AGE: Years 30 Months _____ Days _____ If less than one day
hr. _____ min.

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

10. Usual occupation Subor

11. Industry or business _____

MOTHER FATHER

12. Name Jacob Meyer

13. Birthplace Don't know (City, town, or county) (State or foreign country)

14. Maiden name Don't know

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

16. (a) Informant Vallie Meyer

(b) Address Marshfield Mo R. 3.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 6-43 (Month) (Day) (Year)

(c) Place: burial or cremation Marshfield, Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Marshfield Mo

19. (a) 9-5-43 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4
year 1943 hour 6 minute 50 P.M.

21. I hereby certify that I attended the deceased from Deputy Coroner to Coroner 19____
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death

Fatal Gunshot Wound
of Head

Due to _____

Due to 164c

Other conditions (Include precocity within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy See Above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify type of cause) Suicide

(b) Date of occurrence Sept 4, 1943

(c) Where did injury occur? Jackson City, Mo (City or town) (County) (State)

(d) Did injury occur in or about home on farm, in industrial place, in public place? _____

While at work? No (Specify type of place) (e) Means of injury Gunshot

23. Signature [Signature] (M. D. or other) [Signature]

Address 23 Mead Date signed 9/5/43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SEP 20 1943

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 Paul G. Rowe

Licensed Embalmer No. 2347

P. O. Address K. E. Mo.

Note: The above ~~MUST BE SIGNED BY THE LICENSED EMBALMER~~ **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.