S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 13 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3778

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 1314

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: Saint Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 411 Blake Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: Sixty years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan 011
(c) City or town: Saint Joseph 17
(If outside city or town limits, write "RURAL")
(d) Street No.: 411 Blake Street
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Mrs. Helen Davis Meyer
3. (b) If veteran, name war: ____
3. (c) Social Security No.: NONE
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: Charles W. Meyer
6. (c) Age of husband or wife if alive: ____ years
7. Birth date of deceased: July (Month) 30 (Day), 1878 (Year)

8. AGE:

Years	Months	Days	If less than one day
65	3	26	____ hr. ____ min.

9. Birthplace: Unknown (City, town, or county) Kansas (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ____
12. FATHER Name: Unknown Davis
13. FATHER Birthplace: Unknown (City, town, or county) Unknown (State or foreign country) 9
14. MOTHER Maiden name: Unknown Unknown
15. MOTHER Birthplace: Unknown (City, town, or county) Unknown (State or foreign country) 9
16. (a) Informant: Mrs. Chas W. Meyer
(b) Address: Camp Shelby, Mississippi
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 29, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Ashland Cemetery
18. (a) Signature of funeral director: Mrs. E. R. Sidenfader
(b) Address: 602 South 10th Street
19. (a) 11-27-43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26th year 1943 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from Nov 26 1943 to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Brights Disease — Duration: 4 days
Due to: Carcinoma of the right mammary gland — 6 mos
Due to: Chronic Diabetes — 30 yrs.
Other conditions (Include pregnancy within 3 months of death): Woman died at her home after a four days of Coma.
Major findings: Of operations: ____
Of autopsy: No. 50

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

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: H. F. Mundy Coroner (M. D. or other)
Address: 404 S 3d St Joseph, Mo Date signed: 11/26/43

1233 (Licensed Embalmer's Statement on Reverse Side)

DEC 2 9 1943

OCT 1 7 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 Mollie E. Siedenfaden Fro

Licensed Embalmer No. 4235

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.