

V. S. No. 2
100M-8-43
Rev. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31781

FILED SEP 18 1944

State File No. _____

Registration District No. 317

Primary Registration District No. 2069

Registrar's No. 7875

1. PLACE OF DEATH:

(a) County St. Louis, Missouri *RIH*

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)

In this community 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 96

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3929 Labadie Ave
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Virginia Meyer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased September 5th 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day hr. min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: _____

11. Industry or business: _____

MOTHER FATHER { 12. Name Frank Meyer

{ 13. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

{ 14. Maiden name Jane Meyer

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

16. (a) Informant Mr. Frank Meyer-father

(b) Address 3929 Labadie Avenue

17. (a) burial (b) Date thereof 9/8/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Interment Calvary Cemetery

18. (a) Signature of funeral director Sullivan Brothers

(b) Address 2849 North Euclid Avenue

19. (a) SEP 7 1944 (b) C. L. McKeamy, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 6th
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 9-5-1944 to 9-6-1944
that I last saw her alive on 9-6- 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration

1. ateleclasis

Due to _____

2. Pre-maturity

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____ 159

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? _____

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

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

Address Inter Med. H. Co., Mo. Date signed 9-6-44

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

62036

Dr. Garry Jones
Luther Bedy, F03800
Eugene H. Bellman
216

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 Eugene H. Bellman
Licensed Embalmer No. 2930
P. O. Address.....

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.