

FILED JAN 20 1945

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

568

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 180

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
DePaul Hospital  
(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 Mo. (b) County St. Louis  
(c) City or town Pine Lawn  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5312 Hodiament Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Julius Meyer, Sr.

3. (b) If veteran, name war No 3. (c) Social Security 488-03-7417

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

6. (b) Name of husband or wife Margaret Meyer 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased June 19, 1878  
(Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Printer

11. Industry or business \_\_\_\_\_

12. Name Julius Meyer

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

14. Maiden name Gertrude Brueggelrod  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Margaret Meyer

(b) Address 5312 Hodiament Ave.

17. (a) Burial (b) Date thereof Jan. 9/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiament Ave.

19. (a) JAN 8 1945 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6  
year 1945 hour 11 minute 45 A. M.

21. I hereby certify that I attended the deceased from Sept 14 to Jan 6 1945  
that I last saw him alive on Jan 6 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis with chronic myocarditis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(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) (e) Means of injury \_\_\_\_\_

23. Signature A. B. O'Connell (M. D. or other) \_\_\_\_\_  
Address 4901 E. Easton Dr Date signed 1/6/45

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

MOTHER FATHER

96  
11  
No. R-1

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. A.F.Henke,  
4901 Easton Ave.,  
Po. 3921.  
I.O.O.F.M.

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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.....

Licensed Embalmer No. 3925

P. O. Address 1125 Hammond Ave.

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.