

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

570

FILED JAN 25 1945 318

Registration District No. _____

1003

Registrar's No. _____

525

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

1. PLACE OF DEATH:

(a) County _____
(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. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME William Meyer Sr.

3. (b) If veteran, name war None 3. (c) Social Security No. _____

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

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

7. Birth date of deceased: January 28, 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 11 19 hr. min.

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

10. Usual occupation: Drug Clerk

11. Industry or business _____

MOTHER FATHER

12. Name: William Meyer

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

14. Maiden name: Katherine Koester

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

16. (a) Informant: Mrs Laura Tooley

(b) Address: 4947 Alcott Ave

17. (a) Burial (b) Date thereof: 1/20/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Friedens' Cemetery

18. (a) Signature of funeral director: Math Hermann & Sons

(b) Address: 2161 East Fair Ave

19. (a) JAN 18, 1945 (b) J. Bredeah
(Date received by Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4947 Alcott Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 16th
year 1945 hour 11:35 minute A. M.

21. I hereby certify that I attended the deceased from 1/5/45
to 1/16/45

that I last saw him alive on 1/16/45
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary tuberculosis Duration _____

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: M. O. Lutz Jr. (M. D. _____)

Address: 1515 Lafayette Date signed: 1/16/45

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 *Gustav W. Dietel*
Licensed Embalmer No. *4329*
P. O. Address *St. Louis, 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.