

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 571
Registrar's No. 447

FILED JAN 25 1945
318

Registration District No. _____ Primary Registration District No. 100

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether 0)

In this community 42 years
years, months or days

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. 2804 Delmar
(If rural, give location)

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

3. (a) PRINT FULL NAME John Meyers

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or Race Colored

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

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

7. Birth date of deceased January 29, 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

66 11 28 _____ hr. _____ min.

9. Birthplace Pa Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name White Meyers

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

{ 14. Maiden name Susan Sawyers

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

16. (a) Informant Shirley M. Smith

(b) Address 2601 N. Whittier

17. (a) Burial (b) Date thereof Jan 16, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fisher Decker

18. (a) Signature of funeral director English Ind. Co

(b) Address 2931 Lusk Ave

19. (a) JAN 16 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

100

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9
year 1945 hour 11 minute 55 A.M.

21. I hereby certify that I attended the deceased from January
5, 1945 to January 9, 1945
that I last saw h. in alive on January 9, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Syphilitic Heart Disease

Duration Unk.

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 0

23. Signature Alma Mason (M. D. _____)
Address 2801 Whittier Date signed 1/16/45

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

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

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 Buckson English

Licensed Embalmer No. 4208

P. O. Address 2931 Lucas 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.

Registration District No. 318

Primary Registration District No. 1003

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:
(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)

3. (a) PRINT FULL NAME John Meyer

3. (b) If veteran, name war..... (c) Social Security No.....

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased Jun 29 (Month) (Day) (Year)

8. AGE: Years 60 Months 11 Days 10 (If less than one day, specify in min.)

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

10. Usual occupation laborer

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) JAN 30 1945 (b) J. F. Brudick (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 year 1945 hour 2 minute 15 M.

21. I hereby certify that I attended the deceased from..... that I last saw him..... alive on..... and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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.....

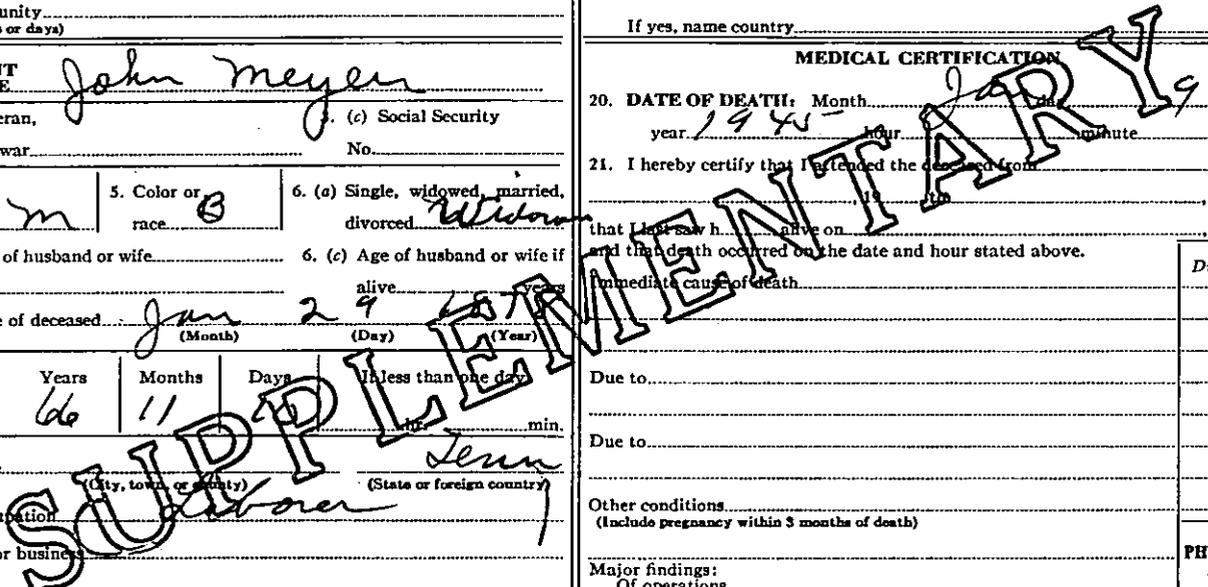
(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? While at work? (Specify type of place) (e) Means of injury.....

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

Address..... Date signed.....

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



MOTHER FATHER

