

FILED APR 13 1945

Registration District No. _____

Primary Registration District No. 3010

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(c) Name of hospital or institution: Spring & Wood Hope
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community all life 20 yrs
years, months or days

3. (a) PRINT FULL NAME Miss Edna Meier

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

4. Sex Female 5. Color or race W 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 Aug. 4 - 1898
(Month) (Day) (Year)

8. AGE: Years 46 Months 7 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Jackson Mo. S
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business _____

12. Name Gustave Meier

13. Birthplace Cape County Mo. S
(City, town, or county) (State or foreign country)

14. Maiden name Therese Meier

15. Birthplace Cape Girardeau Mo. S
(City, town, or county) (State or foreign country)

16. (a) Informant Edna Meier

(b) Address Cape Girardeau Mo

17. (a) Burial (b) Date thereof 3-11-45
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jackson Mo.

18. (a) Signature of funeral director J. H. Haydel

(b) Address Cape Girardeau Mo.

19. (a) 3-11-45 (b) V. P. Phelps
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
(c) City or town Cape Girardeau IL
(d) Street No. 320 W Blvd
(e) Citizen of foreign country? No (Yes or No) 4
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9th
year 1945 hour 2 minute 47 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to Chronic Myocarditis

Due to _____

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

Major findings: Of operations ASD
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) _____ (Means of injury) h

23. Signature Dr. J. S. ... (M. D. or other) Coroner

Address Jackson Mo Date signed 3/10/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

6
1
4

1014

RECEIVED

District Health Officer No. 4
District File Number 445-465
Date Filed 4-9-45

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 J. Howell
Licensed Embalmer No. 3391
P. O. Address Dupe

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.