

FILED JAN 11 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39529
Registrar's No. 11390

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. JOHNS 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

3. (a) PRINT FULL NAME DUNCAN LOZZO MEEK
3. (b) If veteran, name war _____ 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 ANNETTE DUPARRI 6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased SEPT 20 1990
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 3 5 hr. min.

9. Birthplace TENN. (City, town, or county) (State or foreign country)
10. Usual occupation STREET CAR MOTORMAN
11. Industry or business PUBLIC SERVICE

MOTHER FATHER

12. Name WILLIAM MEEK
13. Birthplace TENN (City, town, or county) (State or foreign country)
14. Maiden name MARY WADE
15. Birthplace TENN (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Annette Meek
(b) Address 2920 Chippewa Ave.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/28/45 (Month) (Day) (Year)
(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director J. Mullen Und. Co.
(b) Address 5165 Delmar Blvd
19. (a) DEC 27 1945 (Date received local registrar) J. F. Brunck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County _____
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")
(d) Street No. 5181 DELMAR BL. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 25th
year 1945 hour 1 minute 9 M.
21. I hereby certify that I attended the deceased from Nov 30 1945 to Dec 25 1945
that I last saw him alive on Dec 24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death terminal
Phonleisis
Duration _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 R. Byland (M. D. or other) _____
Address 3903 Park Ave Date signed _____

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.....

H. G. Farris

Licensed Embalmer No. *3384*

P. O. Address.....

H. G. Farris

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.