

FILED JUL 11 1948
273

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21064**
Registrar's No. **47**

Registration District No. **273**

Primary Registration District No. **5916**

1. PLACE OF DEATH:
(a) County **Perry**
(b) City or town **Rural Cinque Homme**
(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 **84-3-12**
In this community **84-3-12**
years, months or days

3. (a) PRINT FULL NAME **Frank J. Meister**
3. (b) If veteran, name war _____
3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mary Meister** 6. (c) Age of husband or wife if alive **77** years
7. Birth date of deceased **February 12 1862**
(Month) (Day) (Year)

8. AGE: Years **84** Months **3** Days **12** If less than one day
hr. _____ min.

9. Birthplace **Perry Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

MOTHER FATHER { 11. Industry or business _____
12. Name **Joseph Meister**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Theresa Eggers**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary Meister**
(b) Address **Highland Mo.**

17. (a) **Burial** (b) Date thereof **5-27-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Highland Mo.**

18. (a) Signature of funeral director **Young & Sons**
(b) Address **Perryville Mo.**

19. (a) **5-25-46** (b) **Joe J. Zellman**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Perry**
(c) City or town **Rural**
(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 **May** day **24**
year **1946** hour **4** minute **10 A.M.**

21. I hereby certify that I attended the deceased from **10-21** 19 **42** to **5-24** 19 **46**
that I last saw him alive on **May 19** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremic Hemiplegia** Duration **13 days**
Due to **Urinary retention** approx. **3yrs.**

Due to **Probable Cancer of Prostate and Bladder** Unknown

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 **2**

23. Signature **E. J. Jahan** (X DO or other)
Address **Perryville Mo.** Date signed **May 25/46**

RECEIVED

District Health Officer No. 4
District File Number 746-23
Date Filed 7-10-4

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 Walter Young.....

Licensed Embalmer No. 4027.....

P. O. Address Perryville Mo.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 478

Registration District No. 273

Primary Registration District No. 5916

1. PLACE OF DEATH: Perry
(a) County Perry
(b) City or town Rural
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Frank J. Meister
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced on
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Feb 12 (Month) (Day) (Year)

8. AGE: Years 44 Months 3 Days _____ (If less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

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 _____ year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 _____

Due to Carcinoma of Prostate

Due to _____ 516

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

Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration _____
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) Dr. J. Gahan

Address Arkville Mo Date signed July 16 1946

SUPPLEMENTARY

MOTHER FATHER

21064