

No. 2  
OM-5-43  
v. 5-17-39  
I X36671

27256

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

**FILED** AUG 27 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 3467

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Research Hospital 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

In this community 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Jackson 999

(c) City or town Elmhurst  
(If outside city or town limits, write "RURAL")

(d) Street No. XX (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country No.

3. (a) PRINT FULL NAME MARGARET MEYER

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced single 0

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

7. Birth date of deceased October 27 1938  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18 year 1946 hour 1 minute P M.

21. I hereby certify that I attended the deceased from 9 August 10, 1946, to August 11, 1946 that I last saw her alive on August 11, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE:

Years	Months	Days	If less than one day
<u>7</u>	<u>9</u>	<u>14</u>	hr. _____ min. _____

Duration \_\_\_\_\_

Due to Acute Ceribitis

Due to Polio acute myelitis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

10. Usual occupation XX

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: 36  
-Of operations \_\_\_\_\_

Of autopsy see above

MOTHER FATHER

11. Industry or business XX

12. Name Arthur Meyer 0

13. Birthplace Missouri (City, town, or county) (State or foreign country) 0

14. Maiden name Dorothy Pape 0

15. Birthplace Missouri (City, town, or county) (State or foreign country) 0

16. (a) Informant Arthur Meyer

(b) Address Elmhurst, Illinois

17. (a) Burial (b) Date thereof Aug. 13, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concordia, Missouri

18. (a) Signature of funeral director James Funeral Home

(b) Address Concordia, Missouri

19. (a) 8-11-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

23. Signature Harry M. Sully (M. D. or other) \_\_\_\_\_  
Address 1624 Prof Bldg. Date signed \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

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

48  
39  
8

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**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 Chas E. Wilks

Licensed Embalmer No. 2644

P.O. Address Kansas City 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.**