

No. 2  
5-43  
-17-39  
X26671

**FILED** SEP 21 1946  
318

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8792**

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

**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:  
2407a N. Jefferson Ave.  
(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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 0001

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 2407a N. Jefferson Ave.  
(If rural, give location)

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

**3. (a) PRINT FULL NAME** Harry H. 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 M /

6. (b) Name of husband or wife Elizabeth

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased December 25, 1866  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>79</u>	<u>9</u>	<u>17</u>	hr. min.

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

10. Usual occupation.....

11. Industry or business nil

MOTHER FATHER

12. Name Dont Know

13. Birthplace Unknown  
(State or foreign country)

14. Maiden name Dont Know

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

16. (a) Informant Mrs. Elizabeth Meek,

(b) Address 2407a N. Jefferson Ave.

17. (a) Burial (b) Date thereof 10-14-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Cullinane Bros.

(b) Address 3320 N. Kingshighway Blvd.

19. (a) OCT 14 1946 J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month October day 12  
year 1946 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from Sept. 21  
1946 to Oct. 12 1946  
that I last saw h. alive on Oct. 11 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 5 y.

Due to.....

Due to.....

Other conditions Coronary disease 5 y.  
(Include pregnancy within 3 months of death)

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) (c) Means of injury

23. Signature William H. Grundmann M.D. (M. D. or other)

Address 2519 N. Jefferson Ave. Date signed 10/12/46

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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.....

*Fred Frick*

Licensed Embalmer No.....3186.....

P. O. Address *St. Louis, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Nov  
Registrar's No. 8792

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 Hans H. Meek  
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 Married

6. (b) Name of husband or wife Elizabeth  
6. (c) Age of husband or wife if alive 25 years

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

8. AGE: Years Months Days  
79 9 1  
(Less than one day hr. min.)

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER  
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.....  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address.....

19. (a)..... (b) J. F. Bredeh  
(Date received local registrar) (Registrar's signature) NOV 1945

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..... Day.....  
year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....  
to..... 19.....  
that I last saw h..... alive on..... 19.....  
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

SUPPLEMENTARY

35401