

No. 2
-12-45
5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5469**
Registrar's No. **70**

FILED FEB 24 1947

Registration District No. **209**

Primary Registration District No. **3043**

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Hannibal**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Elizabeth Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pike**
(c) City or town **Bowling Green, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **LAURA ELIZABETH MEYER**

3. (b) If veteran, name war **X**
3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**

6. (c) Age of husband or wife if alive **47** years
7. Birth date of deceased **Feb 6 1902**
(Month) (Day) (Year)

8. AGE: Years **45** Months **7** Days **7**
If less than one day hr. _____ min. _____

9. Birthplace **Pike Co Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **Elementa Hoste**

13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna P. Hoste**

15. Birthplace **Hermann Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Gerald W. Meyer**

(b) Address **Bowling Green Mo.**

17. (a) **Burial** (b) Date thereof **Feb 10 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Clements Mo.**

18. (a) Signature of funeral director **Grace Benhead**

(b) Address **Bowling Green Mo.**

19. (a) **2-10-47** (b) **Dr. E. M. Lucke**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **10th** year **1947** hour **5:30** minute **9** M.

21. I hereby certify that I attended the deceased from **Feb. 10th 1947** to **Feb. 10th 1947**; that I last saw her alive on **Feb. 10th 1947**; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to **arterio-sclerosis**

Due to _____

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

Major findings: Of operations _____

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? _____

23. Signature **J. B. Briggs M.D.** (M. D. or other)
Address **Bowling Green, Mo.** Date signed **2/11/47**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

189

(Licensed Embalmer's Statement on Reverse Side)

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 *Grace M. Danforth*

Licensed Embalmer No. *2204*

P. O. Address *Bowling Green 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.