

FILED MAY 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13979

Registration District No. 112

Primary Registration District No. 3034

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Higginsville, Missouri
(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 45 years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Cecilia Meyer

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

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

6. (b) Name of husband or wife Henry F. Meyer 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased March 4th 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 1 15 hr. min.

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

10. Usual occupation House Wife

11. Industry or business

12. Name Joseph Meyer
13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Mary Kopp
15. Birthplace Washington, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Henry F. Meyer
(b) Address Higginsville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/47
(Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Catholic

18. (a) Signature of funeral director M. W. Adams
(b) Address Higginsville, Mo.

19. (a) Apr 23 - 47 (b) Clayton W. Landrum
(Date received local registrar) (Registrar's signature) (151)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Higginsville, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. West 29th Street
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19th
year 1947 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from May 1943
19 to April 19th 19 47
that I last saw h er alive on April 19, 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Pulmonary Edema
Due to Chronic myocarditis 5 yrs
with general ascites
Due to Dementia 10 yrs.

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:

(c) 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?

(Specify type of place) While at work?..... (c) Means of injury.....

23. Signature E. W. Adams Sr. (M. D. or other)
Address Higginsville, Mo. Date signed 4-21-47

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 5-2-17

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 *Robert Reddy*
Licensed Embalmer No. 4284
P. O. Address SPRINGVILLE, 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.