

No. 2
-1/47
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33572**

FILED OCT 29 1947

Registration District No. _____ Primary Registration District No. **3000** Registrar's No. **286**

1. PLACE OF DEATH:

(a) County **Adair**

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

(c) Name of hospital or institution **Grim-Smith Hospital & Clinic**
(If not in hospital or institution, write street and location)

(d) Length of stay: In hospital or institution **14 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Putnam**

(c) City or town **Unionville,**
(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 **August Cicero Meyer**

3. (b) If veteran, name war **M**

3. (c) Social Security No. _____

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive **4** years **1878**

7. Birth date of deceased **April 4 1878**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
69	6	9	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name **Ferdinand Sophus Meyer,**

13. Birthplace **Copenhagen, Denmark**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Meyer**

15. Birthplace **Dubuque, Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jimmie Meyer**

(b) Address **Wassonville, Mo**

17. (a) **B** (Burial, cremation, or removal)

(b) Date thereof **Oct 16, 47**
(Month) (Day) (Year)

(c) Place: burial or cremation **Wassonville, Mo**

18. (a) Signature of funeral director **[Signature]**

(b) Address **Wassonville, Mo**

19. (a) **10-22-47** (Date received local registrar)

(b) **Kate Lambert** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October,** day **13th**
year **1947** hour **8:00 A.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **28 Sept., 1947** to **13 Oct., 1947**
that I last saw him alive on **13 Oct., 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Septic**

Duration **1 yr.**

Due to _____

Due to _____

Other conditions **Prostatic hypertrophy, Eyes**
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____

Of operations **731 B**

Of autopsy _____

Underline the cause of 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? _____ (Specify type of place)

While at work _____ (e) Means of injury _____

23. Signature **[Signature]** (M. D. or other) **MD**
Address **Wassonville, Missouri** signed **10/13/47**

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

MOTHER FATHER

JAN 13 1948

SEP 10 1953

DEC 6 1948

RECEIVED
District Health Officer No. 10
District File Number 10-47-1451
Date Filed OCT 27-1947

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..... *Marie E. Husted*
Licensed Embalmer No. *3304*
P. O. Address..... *Massachusetts*

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.