

FILED DEC 31 1947  
Registration District No. **2**

Primary Registration District No. **6076**

Registrar's No. **2698**

1. PLACE OF DEATH:

(a) County **St. Louis**

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

(c) Name of hospital or institution:  
**2158 Fairhaven Drive**  
(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 **St. Louis** **96**

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

(d) Street No. **2158 Fairhaven Drive**  
(If rural, give location)

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

3. (a) PRINT FULL NAME **Gus F. Meier**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **499-12-6877**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **25**  
year **1947** hour **3** minute **20** P. M.

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Dorothy**

6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **Dec. 20 1889**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **10/1/47** to **12/25/47**

that I last saw ~~him~~ **her** alive on **12/25/47** and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>58</b>	<b>0</b>	<b>5</b>	.....hr. ....min

Immediate cause of death **Ca of Rectum**

Due to **460**

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

10. Usual occupation **Painter**

Due to.....

Other conditions.....  
(include pregnancy within 3 months of death)

11. Industry or business **Naval Air Base**

12. Name **Charles W. Meier**

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

14. Maiden name **Johanna Kohlmeier**

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

Major findings:  
Of operations.....

Of autopsy.....

PHYSICIAN  
Underline the cause of which death should be charged statistically.

16. (a) Informant **Mrs. Dorothy Meier**  
(b) Address **2158 Fairhaven Drive.**

17. (a) **Burial** (b) Date thereof **12/28/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters Cemetery Provost Und. Co.**

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)

18. (a) Signature of funeral director.....  
(b) Address **3710 N. Grand Blvd.**

19. (a) **12-28-47** (b) **Charles W. Meier**  
(Date received local registrar) (Registrar's signature)

While at work?.....

(e) Means of injury.....

23. Signature **[Signature]** (M. D. or other) **[Signature]**  
Address **[Signature]** Date signed **12/25/47**

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

76  
0  
0

Dr. H. J. Johnson  
6807 W. 4th  
2-4

MAR 26 1952  
JAN 7 1948

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 Albert Mayfield  
Licensed Embalmer No. 3077

P. O. Address \_\_\_\_\_

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.