No. 2
12-45
47-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 30 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2139

State File No.

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 17

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1003 N. Benton Avenue
(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. Charles 92
(c) City or town St. Charles 9
(If outside city or town limits, write "RURAL")
(d) Street No. 1003 North Benton Avenue 3
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Henry C. Meyer
3. (b) If veteran, name war None
3. (c) Social Security No.
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married 1
6. (b) Name of husband or wife Ida Grau
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased August 15, 1873 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	74	4	22	hr. min.

9. Birthplace St. Charles County (City, town, or county) Missouri (State or foreign country) 6
10. Usual occupation Retired
11. Industry or business
FATHER
12. Name Herman Meyer 1
13. Birthplace (City, town, or county) Germany (State or foreign country) 4
MOTHER
14. Maiden name Hallemeier 0
15. Birthplace (City, town, or county) St. Charles, Mo (State or foreign country)
16. (a) Informant Mrs. Ida Meyer
(b) Address 1003 N. Benton Ave., St. Charles, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation St. Johns Cemetery
18. (a) Signature of funeral director Hackmann-Baur, Inc
(b) Address 326 N. 6th Str., St. Charles, Mo.
19. (a) 1-27-48 (Date received local registrar) (b) Fannie Hamilton (Registrar's signature) 7 oc

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 7
year 1948 hour 8 minute 35 PM.
21. I hereby certify that I attended the deceased from Dec 8th, 1947, to Jan 8th, 1948.
that I last saw him alive on Jan 8th, 1948.
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion	5 Min
Due to: Myocardial insufficiency	10 Mo.
Due to: Gen. Arteriosclerosis.	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy — 93 D

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? 0
(Specify type of place)
While at work? (e) Means of injury
23. Signature A P Erich Schulz M.D. (M. D. or other)
Address St Charles Mo. Date signed 1/9/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JAN 29 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 Arthur C. Bauer

Licensed Embalmer No. 3155

P. O. Address St Charles 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.

No. 2B
M—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. FN

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 17

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town St Charles
(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Henry C. Meyer

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased May 15 1888
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days If less than one day hr. min.

9. Birthplace No
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) Jan 27/48 (Date received local registrar) (b) Fannie Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year 1948 hour P. minute M.

21. I hereby certify that I attended the deceased from , 19 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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-2139