

FILED AUG 17 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25445**

Registration District No. **31**

Primary Registration District No. **4040**

Registrar's No. **25**

1. PLACE OF DEATH:

(a) County **Benton**
(b) City or town **Cole Camp**
(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: _____
In this community **1 year 10 Months**
years, months or days (Specify whether years, months or days)

3. (a) PRINT **Herman Meyer**
FULL NAME

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

4. Sex **Male** 0
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Maggie**
6. (c) Age of husband or wife if alive **72** years
7. Birth date of deceased **February 12th 1871**
(Month) (Day) (Year)

8. AGE: **77** Years Months Days If less than one day
5 30
hr. min.

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

10. Usual occupation **Retired Farmer**

MOTHER FATHER {
11. Industry or business
12. Name **Herman Meyer**
13. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Otten**
15. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Maggie Meyer**
(b) Address **Cole Camp Mo**

17. (a) **Burial** (b) Date thereof **Aug 13, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Trinity Lutheran Cemetery**

18. (a) Signature of funeral director **E. H. Eckhoff**

(b) Address **Cole Camp Mo**

19. (a) **8-12-1948** (b) **E. H. Eckhoff**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Benton** 8
(c) City or town **Cole Camp** 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **11**
year **1948** hour **5** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **8-1-48**, 19, to **8-11-48**, 19;
that I last saw him alive on **8-11-48**, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Failure**
Due to **High Static Pneumonia**
Due to _____

Other conditions (Include pregnancy within 3 months of death) **MI**

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature **P. W. Moreland** (M. D. or other) **MD**
Address **Cole Camp, Mo** Date signed **8-12-48**

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

RECEIVED
District Health Officer
District File Number 7-48-24
Date Filed 8-16-48

APR 11 1951

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..... *E. F. Eickhoff*.....
Licensed Embalmer No..... 730.....
P. O. Address..... Cole Camp 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.