

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25302
State File No. 25302
Registrar's No. 6144

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Missouri b. COUNTY 000 | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 17 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 4723 Newcomb Place | | d. STREET ADDRESS (If rural, give location) 4723 Newcomb Place 0 | |

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|---|--|------------------------|--|--|--|--|--|------------------------------------|------------------------------|-----------------------------|--|-----------------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Lillie | | b. (Middle) Meyer | | c. (Last) Sloss | | 4. DATE OF DEATH (Month) (Day) (Year) July 12, 1949 | | | | | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | | 8. DATE OF BIRTH Nov. 25, 1870 | | 9. AGE (In years last birthday) 78 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 0 | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |

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|--|--|--|--|--|--|
| 13a. FATHER'S NAME John J. Meyer | | 13b. MOTHER'S MAIDEN NAME Anna Powe | | 14. NAME OF HUSBAND OR WIFE William Perry Sloss | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Nell Sloss - 4723 Newcomb Pl. | |

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|---|--|---|--|--|--|--|--|---|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arterio Sclerosis | | | | | | | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General arterio sclerosis | | | | | | | |
| | | DUE TO (c) | | | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |

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|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 977 | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? H500 | | | |

22. I hereby certify that I attended the deceased from March 23, 1948, to July 12, 1949, that I last saw the deceased alive on July 10, 1949, and that death occurred at 9:15 p. m., from the causes and on the date stated above.

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|--|--|-------------------|--|---|--|---|--|
| 23a. SIGNATURE 41 Anthony - B. Day h. D. | | (Degree or title) | | 23b. ADDRESS 3720 Washington | | 23c. DATE SIGNED 7-7-49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24b. DATE 7/15/49 | | 24c. NAME OF CEMETERY OR CREMATORY St. Peters | | 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo. | |

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|--------------------------------------|--|-----------------------|--|---|--|
| DATE REC'D BY LOCAL REG. JUL 14 1949 | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral - 1905 Union Blvd. | |
|--------------------------------------|--|-----------------------|--|---|--|

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

Dr. A. B. Day ()
Beaumont Bldg.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Albert R. Thompson

Signed _____

Student Embalmer

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.