

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

25525

State File No.

FILED AUG 2 1949

54-287-49

REG. DIST. NO. 317

PRIMARY REG. DIST. NO. 3069

Registrar's No. 1826

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights		c. LENGTH OF STAY (in this place) c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If rural, give location) 6447 Wade Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) THERESA b. (Middle) ANN c. (Last) MEIER			4. DATE OF DEATH (Month) (Day) (Year) July 26, 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 23, 1949
9. AGE (In years last birthday) 3		IF UNDER 1 YEAR Months 3	IF UNDER 4 HRS. Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Louis A. Meier		13b. MOTHER'S MAIDEN NAME Clara B. Sugden	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Louis A. Meier-6447 Wade Ave.
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) atelectasis ANTECEDENT CAUSES DUE TO (b) Prematurity DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7/22, 1949 , to 7/26, 1949 , that I last saw the deceased alive on 7/26, 1949 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Grey Jones, M.D. (Degree or title)		23b. ADDRESS St. Louis, Mo.	23c. DATE SIGNED 7/28/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/27/49	24c. NAME OF CEMETERY OR CREMATORY Resurrection	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
DATE REC'D BY LOCAL REG. 7-28-49	REGISTRAR'S SIGNATURE Herbert R. ...	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser-4228 S. Kingshighway Bl.	

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

96
3

Transcript 10-1

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.

Student _____
Student Embalmer

Signed

Richard W. Stovessand

Licensed Embalmer No. 4007

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.

RS