

FILED DEC 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42016

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 276 PRIMARY REG. DIST. NO. 4410 Registrar's No. 57

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St James mo</u>		c. LENGTH OF STAY (in this place) <u>13 mo</u>	
c. CITY (If outside corporate limits, write RURAL and give township) <u>University City</u>		96	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Soldiers Home Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>7270 Fodorville</u>	
3. NAME OF DECEASED a. (First) <u>August</u> b. (Middle) _____ c. (Last) <u>Meyers</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11-27-49</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 22-1891</u>
9. AGE (In years last birthday) <u>58</u>		If UNDER 1 YEAR: Months <u>2</u> Days <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>St Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Gubian Meyers</u>		13b. MOTHER'S MAIDEN NAME <u>Beatrice Berquist</u>	
14. NAME OF HUSBAND OR WIFE <u>Mary Meyers</u>		_____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>494-07-3650</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mary Meyers</u>		ADDRESS <u>University City 2</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebro-vascular accident</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>hypertensive cordis -</u> DUE TO (c) <u>vascular disease</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>  <u>10 yrs</u>  <u>33 IX</u>	
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) _____		_____	
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? _____		_____	
22. I hereby certify that I attended the deceased from <u>Aug 15</u> , 19 <u>49</u> , to <u>Nov 26</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Nov 26</u> , 19 <u>49</u> , and that death occurred at <u>6:00</u> a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Deceased or title) <u>Ronald Guthrie M.D.</u>		23b. ADDRESS <u>St. Anne, MO</u>	
23c. DATE SIGNED <u>11/22/49</u>		_____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>11-30-49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Cahery and</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis MO</u>	
DATE REC'D BY LOCAL REG <u>Dec 1, 1949</u>		REGISTRAR'S SIGNATURE <u>Cora C. Birmingham</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Oral E. Licklider</u>		ADDRESS <u>St James mo</u>	

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

RECEIVED

Phelps County Health Officer,

County File Number \_\_\_\_\_

Date Filed 12-15-49

DEC 21 1949

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 \_\_\_\_\_

*me*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Oscar E. Licklider

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3544

P. O. Address 97 James St. 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.