

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 24 1950

6

BIRTH NO.		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 3058		Registrar's No.	
1. PLACE OF DEATH a. COUNTY St. Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Charles			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles		c. LENGTH OF STAY (In this place) 8 da.		c. CITY (If outside corporate limits, write RURAL and give township) 0929 OR TOWN St. Peters, Mo.			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Josephs Hospital				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) Ida		b. (Middle) G		c. (Last) Meyers		4. DATE OF DEATH (Month) (Day) (Year) Jan. 14 1950	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 12-17-1874	
				9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN.		11. BIRTHPLACE (State or foreign country) St. Charles, Mo. 0		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Henry Holzfoerster		13b. MOTHER'S MAIDEN NAME Lizetta Stuelmeier		14. NAME OF HUSBAND OR WIFE Frank L. Meyers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS A. J. Meyers, St. Peters, Mo.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 7 days ?	
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) (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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:10 A. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. M. Jenkins, M.D. U				23b. ADDRESS St. Charles, Mo.		23c. DATE SIGNED Jan 16-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-17-50		24c. NAME OF CEMETERY OR CREMATORY All Saints		24d. LOCATION (City, town, or county) (State) St. Peters, Mo.	
DATE REC'D BY LOCAL REG. 1-18-50		REGISTRAR'S SIGNATURE Francie Hamilton		FUNERAL DIRECTOR'S SIGNATURE Geo. Stiefater		ADDRESS St. Peters, Mo.	

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

0923

RECEIVED
JAN 21 1950
District Health Officer No. 9
District File Number

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 Earl Keithly

Licensed Embalmer No. 872

P. O. Address Dallas 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.