

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25654**

FILED AUG 8 1950

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **21864**

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis		
b. CITY OR TOWN Baden Station - RR #4		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Baden Station RR #4 - Box 765		d. STREET ADDRESS (If rural, give location) 4010
d. FULL NAME OF HOSPITAL OR INSTITUTION residence					

3. NAME OF DECEASED (Type or Print) LOTTIE BELLE MEYER		4. DATE OF DEATH (Month) (Day) (Year) 8 # 2 50	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jan. 28, 1872
9. AGE (in years last birthday) 78	IF UNDER 1 YEAR Months 6 Days 4	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Henry W. Vogt	13b. MOTHER'S MAIDEN NAME Delia Newell	14. NAME OF HUSBAND OR WIFE Harman Clyde Meyer
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 Gladys Meyer, Baden Station - Missouri

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cause unknown		INTERVAL BETWEEN ONSET AND DEATH unk
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7955

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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Herbert R. Lomke M.D. (Degree or title) Local Registrar of Vital Statistics	23b. ADDRESS 651 South Brentwood Boulevard	23c. DATE SIGNED 8/3/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) entombment	24b. DATE 8-4-50	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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DATE REC'D BY LOCAL REG. F-3-50	REGISTRAR'S SIGNATURE Herbert R. Lomke M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons - St. Louis, Missouri.
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(Licensed Embalmer's Placement on Reverse Side)

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

S. No. 300
v. 10. 48

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

Clarence H. Murray

Licensed Embalmer No.

4011

P. O. Address

St. Louis, 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.