

FILED DEC 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38166

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 213

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 OR TOWN St Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles	
d. FULL NAME OF HOSPITAL OR INSTITUTION 229 JACKSON ST.		d. STREET ADDRESS (If rural, give location) 429 Jackson St	
3. NAME OF DECEASED (Type or Print) Bertha Meyer		4. DATE OF DEATH (Month) (Day) (Year) Nov 16 1950	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 3 1887
9. AGE (In years last birthday) Months Days 69 7 23		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Keeping		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) St Charles Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Herman Meyer		13b. MOTHER'S MAIDEN NAME Margaret Meyer	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. Nil	
17. INFORMANT'S SIGNATURE OR NAME Esther Meyer		ADDRESS 429 Jackson St St Charles	
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) Coronary occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis DUE TO (c) Gen. Arteriosclerosis 10 yrs. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201	
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)		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 Oct 1st, 1950, to Nov. 16th, 1950, that I last saw the deceased alive on Nov 12, 1950, and that death occurred at 12:30 P.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. Erich Schur M.D.		23b. ADDRESS St Charles Mo.	
23c. DATE SIGNED 11/21/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 19 1950	
24c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		24d. LOCATION (City, town, or county) (State) St Charles Mo.	
DATE REC'D BY LOCAL REG. 11-21-50		REGISTRAR'S SIGNATURE Marie Mueller	
25. FUNERAL DIRECTOR'S SIGNATURE Paul St Charles Mo.		ADDRESS	

File No. _____
DISTRICT HEALTH OFFICE No. 4

DEC 10 1950

RECEIVED

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 Arthur C. Lane

Signed _____
Student Embalmer

Licensed Embalmer No. 3155

P. O. Address St Charles 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.