

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17701**

FILED MAY 16 1951

BIRTH NO. _____		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 3058		Registrar's No. 84	
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) St Charles		c. LENGTH OF STAY (In this place) 36 yrs		c. CITY (If outside corporate limits, write RURAL and give township) St Charles		0923	
d. FULL NAME OF HOSPITAL OR INSTITUTION 436 No. Kingshighway				d. STREET ADDRESS (If rural, give location) 436 No. Kingshighway			
3. NAME OF DECEASED (Type or Print) Sophie		a. (First)		b. (Middle) R		c. (Last) Meyer	
4. DATE OF DEATH May 3 1951		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	
8. DATE OF BIRTH May 5 1859		9. AGE (In years last birthday) 91		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper		11. BIRTHPLACE (State or foreign country) Dieplog Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Curt Klatte		13b. MOTHER'S MAIDEN NAME Carolina Gildehaus		14. NAME OF HUSBAND OR WIFE Henry B Meyer	
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. None		17. INFORMANT'S SIGNATURE OR NAME Henry C Meyer Rt 3 St Charles 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arteriosclerotic Cardio-vascular disease DUE TO (b) DUE TO (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 weeks Undet. Undet.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4221				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) (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 4-1 , 19 51 , to 4-30 , 19 51 , that I last saw the deceased alive on 4-30 , 19 51 , and that death occurred at 8:30 a.m., from the causes and on the date stated above.							
23a. SIGNATURE R.K. M. Lintz M.D.				23b. ADDRESS St. Charles, Mo.		23c. DATE SIGNED 5-7-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 5 1951		24c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		24d. LOCATION (City, town, or county) (State) Orchard Farm Mo	
DATE REC'D BY LOCAL REG. 5-10-51		REGISTRAR'S SIGNATURE Harriet Hamilton		25. FUNERAL DIRECTOR'S SIGNATURE 294 Nathan		ADDRESS Baum St Charles Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

1923

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File No. _____
DISTRICT HEALTH OFFICE No. 4

MAY 14 1951

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.

Student
Student Embalmer

Signed _____

Arthur C. Bane

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.