

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10326

FILED MAR 24 1952

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2151**

1. PLACE OF DEATH
a. COUNTY _____ 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE **MO** b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis, Missouri** c. LENGTH OF STAY (In this place) _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **ST. LOUIS 217.9**

d. FULL NAME OF HOSPITAL OR INSTITUTION **St. Louis City Hospital #1** d. STREET ADDRESS (If rural, give location) **3615 FOLSON**

3. NAME OF DECEASED a. (First) **JOSEPH** b. (Middle) _____ c. (Last) **MEYER** 4. DATE OF DEATH (Month) (Day) (Year) **MAR. 4, 1952**

5. SEX **M** 6. COLOR OR RACE **W** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **M** 8. DATE OF BIRTH **9-8-1890** 9. AGE (In years last birthday) **61** 10. UNDER 1 YEAR Months _____ 11. UNDER 24 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Nil** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) **GERMANY** 12. CITIZEN OF WHAT COUNTRY? **4**

13a. FATHER'S NAME **WIK MEYER** 13b. MOTHER'S MAIDEN NAME **UNKNOWN** 14. NAME OF HUSBAND OR WIFE **ANN MEYER**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME ADDRESS **ANN MEYER 3615 FOLSON**

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.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Carcinoma of nasopharynx** ANTECEDENT CAUSES **Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last:-** DUE TO (b) **= metastases to neck** DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS **Colostomy for chronic diverticulitis**

19a. DATE OF OPERATION **12-7-51** 19b. MAJOR FINDINGS OF OPERATION **Chronic diverticulitis** 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? **146X**

22. I hereby certify that I attended the deceased from **9-10-51**, 19____, to **3-4-52**, 19____, that I last saw the deceased alive on **3-4-52**, 19____. Death occurred at **8:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Donald T. Behrens, M.D.** 23b. ADDRESS **1515 Lafayette Avenue** 23c. DATE SIGNED **3-5-52**

24a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 24b. DATE **3-7-52** 24c. NAME OF CEMETERY OR CREMATORY **CALVARY** 24d. LOCATION (City, town, or county) (State) **ST. LOUIS MO**

DATE REC'D BY LOCAL REG. **MAR 6 1952** REGISTRAR'S SIGNATURE **Carl Smith MA** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **E. Schauer 3125 Lafayette**

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

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

Joseph B. Hollmer

Licensed Embalmer No. *4014*

P. O. Address *7125 Lafayette*

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.