

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21604**

FILED JUN 23 1952

BIRTH NO. _____ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **111**

923
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | |
|---|--|--|--|
| 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. LOUIS | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Robertson | |
| c. LENGTH OF STAY (in this place) 14 Days | | d. STREET ADDRESS (If rural, give location) / | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital | | | |

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|--|-------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) Edwin b. (Middle) S. c. (Last) Meade | | | 4. DATE OF DEATH (Month) (Day) (Year) 6 - 17 - 1952 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 1 - 9 - 1875 | 9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR (Month) (Day) (Year) 5 - 8 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (City and State or Foreign Country) Rolla, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA |

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|---|--|--|--|--|--|
| 13a. FATHER'S NAME John Meade | | 13b. MOTHER'S MAIDEN NAME Sarah Dykes | | 14. NAME OF HUSBAND OR WIFE Oma M. Meade | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Oma M. Meade, Robertson, Mo. | |

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|---|--|---|--|--|---|
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute exacerbation of chronic cholecystitis + cholelithiasis | | | INTERVAL BETWEEN ONSET AND DEATH 8 days |
| 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. Cardiovascular Disease | | | |
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|--|--|--|--|--|--|
| 19a. DATE OF OPERATION 17 June 52 | | 19b. MAJOR FINDINGS OF OPERATION gallstones + necrotic 7-8 mucosa | | 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? 5847 | |

22. I hereby certify that I attended the deceased from **12 Jan, 1950**, to **17 June, 1952**, that I last saw the deceased alive on **17 June 1952** and that death occurred at **7:05P m.**, from the causes and on the date stated above.

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|---|--|--------------------------------------|--|---|--|
| 23a. SIGNATURE (Degree or title) N. E. Hengen M.D. | | 23b. ADDRESS Pattonville, Mo. | | 23c. DATE SIGNED 18 June 52 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 6-20-52 | | 24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery | |
| | | | | 24d. LOCATION (City, town, or county) (State) St. Louis County Mo. | |

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|---|--|---|--|---|--|
| DATE REC'D BY LOCAL REG. 6-18-52 | | REGISTRAR'S SIGNATURE James H. ... | | ADDRESS Drenmann-Harral 1905 Union Blvd. | |
|---|--|---|--|---|--|

1931 10 1937

1111 12 noon of
1v. 1n afternoon
& pickup later

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 Warren A Carver

Licensed Embalmer No. 3534

P. O. Address _____

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.