

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26694**
Registrar's No. **6441**

FILED JUL 31 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		e. STREET ADDRESS (If rural, give location) 2503 Minnesota Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) HELEN b. (Middle) M. c. (Last) MEYER		4. DATE OF DEATH (Month) (Day) (Year) JUNE 27, 1953	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec. 5, 1876
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
13a. FATHER'S NAME August Mosconi		13b. MOTHER'S MAIDEN NAME Elizabeth Kershow	
13c. NAME OF HUSBAND OR WIFE August Meyer		12. CITIZEN OF WHAT COUNTRY?	
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 August Meyer		ADDRESS 2503 Minnesota Ave.	
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) CEREBRAL ARTERIOSCLEROSIS 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.	
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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		334X	
22. I hereby certify that I attended the deceased from 6-16-53 , 19___, to 6-27-53 , 19___, that I last saw the deceased alive on 6-27-53 , 19___, and that death occurred at 5:45P m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Paul G. Larson, M.D.		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 6-29-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 6-30-53	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. JUN 29 1953		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. Kron L&U. Co. 2707N. Grand Blvd.	

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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No..... 45

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.