

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42618**
10849

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

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. CITY OR TOWN Saint Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Home		e. STREET ADDRESS (If rural, give location) 2609 S. Grand Blvd. 2179	

3. NAME OF DECEASED (Type or Print) JOHN F. MEEK			4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1954		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 26, 1862	9. AGE (In years last birthday) 92	10. UNDER 1 YEAR Months	10. UNDER 1 YEAR Days	10. UNDER 1 YEAR Hours	10. UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Czechoslovakia 6	12. CITIZEN OF WHAT COUNTRY? Same
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13a. FATHER'S NAME John Mik	13b. MOTHER'S MAIDEN NAME Catherine Hess	14. NAME OF HUSBAND OR WIFE not known
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Wainwright, 2609 S. Grand Blvd.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Diabetes Mellitus</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Senility</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? <i>260X</i>
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22. I hereby certify that I attended the deceased from 1949 to 11-27, 1954, that I last saw the deceased alive on 11-26, 1954, and that death occurred at 9:30 A. M., from the causes and on the date stated above.

23a. SIGNATURE <i>Edward Welby M.D.</i>	(Degree or title) M.D.	23b. ADDRESS <i>3903 Olive St. Louis 8</i>	23c. DATE SIGNED <i>11-27-54</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE Nov. 30, 1954	24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	24d. LOCATION (City, town, or county) (State) St. Louis County
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DATE REC'D BY LOCAL REG. NOV 29 1954	REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE CRAIG, 4700 Washington -8-	ADDRESS
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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 *Robert M. Murray*
Licensed Embalmer No. *3749*

P. O. Address *St. Louis*

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.