

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21276**

FILED AUG 15 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **5126** Registrar's No. **840**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural: Crawford Twp.</b>	c. LENGTH OF STAY (in this place) <b>life</b>	c. CITY OR TOWN <b>Dearborn</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1 1/2 mile south of Wallace, Mo.</b>		f. STREET ADDRESS (If rural, give location) <b>R. R. #2</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>George</b> b. (Middle) c. (Last) <b>Meek</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>August 5, 1955</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>March 29, 1871</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Buchanan County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>James Meek</b>		13b. MOTHER'S MAIDEN NAME <b>Cynthia Boyles</b>		14. NAME OF HUSBAND OR WIFE <b>Florence</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Florence Meek, R.R. #2, Dearborn, Mo.</b>	

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Arteriosclerotic Heart Disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Disease</b> <b>4200</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> <b>unknown</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>(man died at his home while his attending doctor was away)</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>(on a vacation)</b>		19c. 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)	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 **on 8/6 1955**, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **5:30 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>H. F. Mundy (Coroner)</b>		23b. ADDRESS <b>St. Joseph, Mo.</b>		23c. DATE SIGNED <b>8/6/55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>8/7/1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Judah Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Buchanan County, Missouri</b>	

DATE REC'D BY LOCAL REG. <b>Aug 9, 1955</b>	REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>	485	25. FUNERAL DIRECTOR'S SIGNATURE <b>Heaton Bowman</b>	ADDRESS <b>St. Joseph, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

*Dr. J. M. ...*

**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 *Quilad D. Collins*

Licensed Embalmer No. *495*

P. O. Address *St. Joseph*

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.