

FILED AUG 2-1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **23330**BIRTH NO. _____ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **1876**

1. PLACE OF DEATH a. COUNTY St Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE MO b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St Charles		c. CITY (If outside corporate limits, write RURAL and give township) Oberland	
c. LENGTH OF STAY (If this place) 7 Days		d. STREET ADDRESS (If rural, give location) 3211 Airway	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Josephs Hospital			

3. NAME OF DECEASED (Type or Print) HELEN MEYER			4. DATE OF DEATH (Month) (Day) (Year) 7-23-55	
a. (First)	b. (Middle)	c. (Last)		

5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 6-24-1881	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months Days	IF UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS	10b. KIND OF BUSINESS OR INDUSTRY SELF	11. BIRTHPLACE (State or foreign country) ST LOUIS MO	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME JOHN MEYER	13b. MOTHER'S MAIDEN NAME LOUISE RITTMAYER	14. NAME OF HUSBAND OR WIFE SINGLE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS JOHN MEYER 7550 PERSHING
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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, ashenia, 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) Chronic myeloid Leukemia		?
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 2041 DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. generalized arteriosclerosis			?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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?
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22. I hereby certify that I attended the deceased from **15 July, 1955**, to **23 July, 1955**, that I last saw the deceased alive on **23 July, 1955**, and that death occurred at **3:11 P.M.**, from the cause and on the date stated above.

23a. SIGNATURE (Degree or title) H. E. Hengeman M.D.	23b. ADDRESS Pattonville, Mo.	23c. DATE SIGNED 24 July 55
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 7-26-55	24c. NAME OF CEMETERY OR CREMATORY BETHANY CEMETERY	24d. LOCATION (City, town, or county) (State) WELLSVILLE MO
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DATE REC'D BY LOCAL REG. July 24 1955	REGISTRAR'S SIGNATURE Francis Hamilton	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS EARL HILLMAN 9709 BLACKLAND
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Emil Hillman

Licensed Embalmer No. *3501*

P. O. Address *Osland 14*

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.