

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

18315

State File No. \_\_\_\_\_

3906

FILED MAY 25 1956

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

|   |  |   |  |                                  |  |
|---|--|---|--|----------------------------------|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY |  |                                  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b> |  | c. LENGTH OF STAY (in this place) <b>DOA</b>  |  | c. CITY OR TOWN <b>St. Louis</b> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>                |  | e. STREET ADDRESS (If rural, give location) <b>4960a Delmar</b>   |  |                                  |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| <b>3. NAME OF DECEASED</b><br>(Type or Print) a. (First) <b>Samuel</b> b. (Middle) <b>Kennard</b> c. (Last) <b>Meinberg</b> |  |   | <b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>April 17, 1956</b> |   |  |
| <b>5. SEX</b> <b>Male</b>   |  | <b>6. COLOR OR RACE</b> <b>White</b>                      |  | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Married</b>    |  |
| <b>8. DATE OF BIRTH</b> <b>Feb. 28, 1899</b>  |  | <b>9. AGE</b> (In years last birthday) <b>57</b>          |  | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.                         |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>          |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Insurance</b> |  | <b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>St. Louis, Mo.</b> |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>   |  |   |  |   |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| <b>13a. FATHER'S NAME</b> <b>Samuel Meinberg</b>                                     |  | <b>13b. MOTHER'S MAIDEN NAME</b> <b>Louella Unknown</b> |  | <b>14. NAME OF HUSBAND OR WIFE</b> <b>Floy Meinberg</b>                          |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> |  | <b>16. SOCIAL SECURITY NO.</b> <b>WW 1</b>              |  | <b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Mrs. Floy Meinberg, 4960a Delmar</b> |  |
|  |  |   |  | <b>ADDRESS</b>   |  |

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| <b>18. CAUSE OF DEATH</b><br>Enter only one cause per line for (a), (b), and (c) |  | <b>MEDICAL CERTIFICATION</b>   |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b> |  |
|  |  | <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Internal Hemorrhage from Bleeding Peptic Ulcer.</b>                           |  |  |  |   |  |
|  |  | <b>ANTECEDENT CAUSES</b> <b>Peptic Ulcer.</b>  |  |  |  |   |  |
|  |  | <b>DUE TO (b)</b> _____  |  |  |  |   |  |
|  |  | <b>DUE TO (c)</b> _____  |  |  |  |   |  |
|  |  | <b>II. OTHER SIGNIFICANT CONDITIONS</b> <b>Conditions contributing to the death but not related to the disease or condition causing death.</b> |  |  |  |   |  |

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| <b>19a. DATE OF OPERATION</b>                          |  | <b>19b. MAJOR FINDINGS OF OPERATION</b> <b>540.0</b>  |  |  |  | <b>20. AUTOPSY?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)        |  | <b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | <b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> |  |  |  |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) |  | <b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b>                      |  |  |  |

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **1:35P m.**, from the causes and on the date stated above.

|   |  |                                       |  |   |  |
|---|--|---------------------------------------|--|---|--|
| <b>23a. SIGNATURE</b> <b>Patrick L. Taylor, Coroner</b> (Degree or title) |  | <b>23b. ADDRESS</b> <b>1300 Clark</b> |  | <b>23c. DATE SIGNED</b> <b>4-19-56</b>  |  |
| <b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>           |  | <b>24b. DATE</b> <b>4-20-56</b>       |  | <b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>National Cemetery</b>                  |  |
|   |  |                                       |  | <b>24d. LOCATION</b> (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b> |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| <b>DATE REC'D BY LOCAL REG.</b> <b>APR 19 1956</b> |  | <b>REGISTRAR'S SIGNATURE</b> <b>J. Earl Smith, M.D.</b> |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Albert H. Hoppe, 4700 Washington Blvd.</b> |  |
|  |  |   |  | <b>ADDRESS</b>  |  |

S.P. (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.....  
Signature of Student Embalmer

Signed..... Robert M. Murray  
3749

Licensed Embalmer No. ....

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.