

FILED AUG 13 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23296**

BIRTH NO. _____ REG. DIST. NO. **116** PRIMARY REG. DIST. NO. **3020** Registrar's No. **169**

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Washington		c. CITY OR TOWN Union	d. Is Residence within limits of city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital		STREET ADDRESS (If rural, give location) Cherry St. 23610	

3. NAME OF DECEASED (Type or Print)	a. (First) Wilma	b. (Middle) Annie	c. (Last) Hurst	4. DATE OF DEATH (Month) (Day) (Year) August 3 1956
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH March 11 1893	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 4 Days 22	IF UNDER 24 HRS. Hours Mins
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	10b. KIND OF BUSINESS OR INDUSTRY Creamery	11. BIRTHPLACE (City and State or Foreign Country) Clover Bottom, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jacob J. Meyer	13b. MOTHER'S MAIDEN NAME Lillian Heeger	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 88-03-2197	17. INFORMANT'S SIGNATURE OR NAME Charles D. Meyer	ADDRESS Washington, Mo.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary disease		INTERVAL BETWEEN ONSET AND DEATH Unknown
	ANTECEDENT CAUSES DUE TO (b) etiology unknown		
	DUE TO (c) 521X		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Chronic obstructive heart disease			

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) m.	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 **8/1**, 1956, to **8/3**, 1956, that I last saw the deceased alive on **8/3**, 1956 and that death occurred at **1 P.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]	23b. ADDRESS Union, Missouri	23c. DATE SIGNED 8/4/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/6/56	24c. NAME OF CEMETERY OR CREMATORY St. Peters	24d. LOCATION (City, town, or county) (State) Washington, Franklin, Mo.
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DATE REC'D BY LOCAL REG. 8/4/56	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Union, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

79-0

150 4 30 1919

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..... *E. F. Altman*

Licensed Embalmer No. *168*

P. O. Address *Union*

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.