

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11491  
STATE FILE NUMBER

FILED MAR 18 1957

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 547

Health & Welfare Public Service  
300  
1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
securing the medical certification in the specific manner required by 195.060 symptoms will be listed. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>ST- LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST- LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKWOOD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>KIRKWOOD</u> <u>4673</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST- JOSEPH'S HOSP.</u> Length of stay in 1b <u>D.O.A.</u>		d. STREET ADDRESS (If outside, give location) <u>11300 MANCHESTER</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank J. Meyer</u>			4. DATE OF DEATH Month Day Year <u>FEB. 27, 1957</u>
5. SEX <u>MALE</u> <input type="checkbox"/> <input checked="" type="checkbox"/>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 3, 1879</u>
9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOTELS BUSINESS</u>	11. BIRTHPLACE (City and state or country) <u>ST- LOUIS, MO.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANK MEYER</u>	
14. MOTHER'S MAIDEN NAME <u>FRANCISCA ELIZABETH RICHTER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>CATHERINE MEYER 11300 MANCHESTER</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>8 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>1950</u> to <u>2/27/57</u> and last saw her/him alive on <u>12-28-56</u> Death occurred at <u>10:30A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Edward J. Becken M.D.</u>		22b. ADDRESS <u>205 FRISCO BLDG. ST. LOUIS 1</u>	
22c. DATE SIGNED <u>2/28/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>3/2/57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ST- LOUIS, MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>PFITZINGER MORTUARY, KIRKWOOD</u>		25. DATE REGD. BY LOCAL REG. <u>3/1/57</u>	
26. REGISTRAR'S SIGNATURE <u>Herbert A. Donke</u>			

(Licensed Embalmer's Statement on Reverse Side)

87.

**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.....  
Licensed Embalmer No. 136

P. O. Address.....

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.