

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 15 1957

STATE FILE NUMBER 37851
REGISTRAR'S NUMBER 10306

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis.		c. CITY OR TOWN Florissant 4051	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) R. # 2 VBox 53	
3. NAME OF DECEASED (Type or print) First Clarence Middle J. Last Meyer		4. DATE OF DEATH Month 10 Day 31 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy Farmer		11. BIRTHPLACE (City and state or country) St. Louis County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Charles Meyer		13b. MOTHER'S MAIDEN NAME Anna Holtman	14. NAME OF HUSBAND OR WIFE Wilhelmina Meyer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Nil.	17. INFORMANT Wilhelmina Meyer, R. # 2 Box 53
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease with Stenosis of Aortic Valve. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH one year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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.) 411 X	
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 10-9-57 to 10-31-57 and last saw her/him alive on 10-31-57 Death occurred at 10:45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James P. Murphy, M.D.		22b. ADDRESS 634 North Grand Blvd.	
22c. DATE SIGNED 11-1-57.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-4-57	23c. NAME OF CEMETERY OR CREMATORY Salem Lutheran Cemetery
		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR Diedrich Funeral Home, 8319 Halls Ferry.		25. DATE RECD. BY LOCAL REG. NOV 1 '57	26. REGISTRAR'S SIGNATURE Carl Smith

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

St. Louis

Missouri

X

Flourissant

X

St. Louis

R. # 2 Box 23

Deaconess Hospital

10-1-1927

Hever

1.

Clarence

R-20-1905

X

White

U.S.A.

St. Louis County, Mo.

Dairy farmer

Wilhelmina Hever

Anna Holtman

Charles Hever

Wilhelmina Hever, R. # 2 Box 23
Flourissant, Mo.

No. 111

one hour

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.

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*

Licensed Embalmer No. 3749

P. O. Address *St. Louis, Mo.*

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.

Deaconess Hospital