

Health,
Welfare
Public
Service

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **3307**
REGISTRAR'S NO. **697**

FILED JAN 30 1958

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) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Length of stay in lb 2 days	
4. STREET ADDRESS 6700 Arthur		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Meidroth Last			4. DATE OF DEATH Month January Day 19 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 10, 1877
9. AGE (In years last birthday) 81		10. FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Peoria, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Jacob Becker	
13b. MOTHER'S MAIDEN NAME Mary Meyer		14. NAME OF HUSBAND OR WIFE John S. Meidroth	
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. None	
17. INFORMANT Lucille Hofmann, 6700 Arthur		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH Sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary arteriosclerosis			years
DUE TO (c) Aneurysm			years
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? 2 YES <input type="checkbox"/> NO <input checked="" 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.) 4201	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 Nov 2, 1957 to Jan 15, 1958 and last saw her alive on Jan 19, 1958 Death occurred at 9:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Ann F. Bean (Degree or title) MD		22b. ADDRESS 35th Central - 5 - Mo	
22c. DATE SIGNED 1/20/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE Jan. 22, 1958	
23c. NAME OF CEMETERY OR CREMATORY Valhalla Chapel of Memories		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR Hoffmeister ADDRESS Colonial Mortuary, 6464 Chippewa		25. DATE RECD. BY FINAL REG. JAN 20 58	
26. REGISTRAR'S SIGNATURE Paul Smith MD			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *R. C. Harrison*

Licensed Embalmer No. *4768*
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.