

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009679  
STATE FILE NUMBER

FILED MAR 17 1958

Registration District No. 137

Primary Registration District No. 3023

Registrar's No. 750

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Henry</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Henry</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clinton</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Clinton</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Clinton General Hosp.</b>			Length of stay in lb <b>10 Days</b>	d. STREET ADDRESS (If outside, give location) <b>R. F. D. #4</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>F.</b> Last <b>Meiyer</b>				4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1958</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 14, 1887</b>		9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>25</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurants operator</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Texas Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>August Meiyer</b>			13b. MOTHER'S MAIDEN NAME <b>Katherine Farmer</b>		14. NAME OF HUSBAND OR WIFE <b>Bessie G. Meiyer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>490-16-2420</b>		17. INFORMANT Address <b>Bessie G. Meiyer, Rt. 4, Clinton, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bi-lateral herniorrhaphy</b>						19. WAS AUTOPSY PERFORMED? 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.) <b>4201</b>					
20c. TIME OF INJURY Hour _____ 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 <b>Feb. 28, 1958</b> to <b>Mar. 9, 1958</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>March 9, 1958</b> Death occurred at <b>8:30 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree & title) <i>Samuel Smith M.D.</i>			22b. ADDRESS <b>106 S. Third, Clinton, Mo.</b>		22c. DATE SIGNED <b>3/11/58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 11, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Urlich Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Urlich, Mo.</b>				
24. FUNERAL DIRECTOR <i>W. J. Vansant, Clinton, Mo.</i>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3-11-58</b>		26. REGISTRAR'S SIGNATURE <i>Mildred Bigum</i>		

(Licensed Embalmer's Statement on Reverse Side)

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 *N. J. Vausant* .....

Licensed Embalmer No. *3779* .....  
P. O. Address *Clinton, 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.