

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037323  
STATE FILE NUMBER

FILED NOV 3 1958 Registration District No. 274 Primary Registration District No. 2052 Registrar's No. 409

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>PETTIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>PETTIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SEDALIA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SEDALIA</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>600 North Quincy</b>		Length of stay in lb <b>15 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>600 North Quincy</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>ALBERT</b> Last <b>MEYER</b>			4. DATE OF DEATH Month <b>Oct</b> Day <b>26</b> Year <b>1958</b>		
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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>July 7, 1889</b>	9. AGE (In years last birthday) <b>69</b>	10. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	11. UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Sedalia, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>John D. Meyer</b>	13b. MOTHER'S MAIDEN NAME <b>Anna D. Schmidt</b>	14. NAME OF HUSBAND OR WIFE <b>Mallie Taylor Meyer</b>
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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>None</b>	17. INFORMANT Address <b>Mrs. Mallie Meyer, Sedalia, Missouri</b>
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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>Carcinoma of the Pancreas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</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)		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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	

20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <b>157X</b>	COUNTY _____ STATE _____
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21. I attended the deceased from **10-20-58** to **10-26-58** and last saw <sup>her</sup> him alive on **10-26-58**  
Death occurred at **2 p.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>T. S. Hopkins, M.D.</b>	22b. ADDRESS <b>1609 S. 21st SEDALIA, MO.</b>	22c. DATE SIGNED <b>10-27-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/28/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Sedalia, Missouri</b>
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24. FUNERAL DIRECTOR <b>Thomas Quinn</b>	ADDRESS <b>Sedalia, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>October 28, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Frances Shelby</b>
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

DEC 8 1958

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 *P. E. Baker* .....

Licensed Embalmer No. *2419* .....

P. O. Address *Sedalia, 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.