Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015409
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 3586

MAY 1 1959

1. PLACE OF DEATH
a. COUNTY -
b. CITY OR TOWN ST. LOUIS, MO. — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. # 1 — Length of stay in Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri — COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 207 S. Broadway (If outside, give location) — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First LAT — Middle D. — Last MEEK

4. DATE OF DEATH: Month APRIL — Day 9 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH: 12-25-1886
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 1st. Mate River Boat
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (City and state or country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Jacob Meek
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 402 01 7104a
17. INFORMANT: Lat Meek, 1952 Senate — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Myocardial infarction
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) bleeding duodenal ulcer
DUE TO (c) 541.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
diabetes post operative subtotal gastrectomy

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 3/20/59, to 4/9/59 and last saw her/him alive on 4/9/59
Death occurred at 5:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Rhys A. Williams M.D.
22b. ADDRESS: 1515 LAFAYETTE AVE.
22c. DATE SIGNED: 4/9/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 4-10-1959
23c. NAME OF CEMETERY OR CREMATORY: Salado Cemetery
23d. LOCATION (City, town, or county) (State): Batesville, Arkansas

24. FUNERAL DIRECTOR: McLAUGHLIN'S — ADDRESS: 2301 Lafayette Ave.
25. DATE REC'D BY LOCAL REG.: APR 10 59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

MJB

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 James R. Chapman

Licensed Embalmer No. 4550

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.