

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017159

FILED MAY 15 1959

Registration District No. 77

Primary Registration District No. 4562

STATE FILE NUMBER

Registrar's No. 1

1. PLACE OF DEATH a. COUNTY Cole <i>St. Thomas</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cole	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Thomas</i>		c. CITY OR TOWN <i>St. Thomas 0260</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Home</i>		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) <i>Harvey John Meisel</i>		4. DATE OF DEATH Month Day Year <i>May 11, 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/27/1872</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Cole Co. Mo 0</i>
13a. FATHER'S NAME <i>Unknown</i>		13b. MOTHER'S MAIDEN NAME <i>Unknown</i>	14. NAME OF HUSBAND OR WIFE <i>Elizabeth B. Martin</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Bernard Meisel</i> Address <i>Meta, Mo</i>
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis generalized</i>			INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
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 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 <i>Jan 15/59</i> to <i>May 11/59</i> and last saw him alive on <i>May 11/59</i> Death occurred at <i>6:45 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Quinn Sawyer M.D.</i> (Degree or title)		22b. ADDRESS <i>Jefferson City</i>	22c. DATE SIGNED <i>11/5/59</i>
23a. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE <i>5/13/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Thomas</i>	23d. LOCATION (City, town, or county) (State) <i>St. Thomas</i>
25. DATE RECD. BY LOCAL REG. <i>13 May 1959</i>		26. REGISTRAR'S SIGNATURE <i>R.P. Davis, M.D. - DR</i>	

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 *Walter P. Hayes* .....  
Licensed Embalmer No. *4265* .....  
P.O. Address *Peru 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.