

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026950

FILED VS JUL 24 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 6702**

| | | | | | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|--|--|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo | | Length of stay in 1b | | c. CITY OR TOWN ST. LOUIS | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ENROUTE INCARNATE WORD | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3104 MAGNOLIA | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First EDWARD C. Middle MEYER Last | | | | 4. DATE OF DEATH Month JULY Day 15 Year 1959 | | | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH SEPT 16 1891 | | 9. AGE (last birthday) 67 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASS'T. FOREMAN | | | | 10b. KIND OF BUSINESS OR INDUSTRY UNIVERSAL CAR Mo | | | | 11. BIRTHPLACE (City and state or country) | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 13a. FATHER'S NAME ANDREW MEYER | | | | 13b. MOTHER'S MAIDEN NAME ELIZABETH CRAISER | | | | 14. NAME OF HUSBAND OR WIFE ROSE MEYER | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 489-03-1920 | | 17. INFORMANT ROSE MEYER 3104 MAGNOLIA | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) arteriosclerotic heart disease DUE TO (c) 420.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | | | | | | |
| 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 _____ s.m. _____ p.m. | | Month, Day, Year | | | | | | | | | | | |
| 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 March 56 to July 10th 59 and last saw him alive on July 10th 59 Death occurred in hospital July 15th 4 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE Maximilian Weitzman, M.D. | | | | 22b. ADDRESS 3520 ARSENAL, St. Louis | | | | 22c. DATE SIGNED 7-17-59 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL JULY 18 1959 | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL | | | | 23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo | | | | | |
| 24. GENERAL DIRECTOR Thomas Kates 2906 Season | | | | 25. DATE RECD. BY LOCAL REG. JUL 17 '59 | | 26. REGISTRAR'S SIGNATURE Roan Smith, M.D. | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleana Province

Licensed Embalmer No. 3403

P. O. Address 7906 Jan

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.