

# VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029951

FILED VS AUG 18 1959

Registration District No. 273 Primary Registration District No. 3051 Registrar's No. 93

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Perry</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Perryville</b> Length of stay in lb <b>15 Yrs.</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Perry Co. Mem. Hosp.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Perry</b> c. CITY OR TOWN <b>Perryville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>115 E. South, St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Meyr</b>			<b>4. DATE OF DEATH</b> Month <b>8</b> Day <b>3</b> Year <b>59</b>				
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>4-3-1893</b>	<b>9. AGE (last birthday)</b> <b>66</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>New Wells, Mo.</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>U.S.A.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>Gustav Meyr</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Christine Hochl</b>			<b>14. NAME OF HUSBAND OR WIFE</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>493-30-9835</b>		<b>17. INFORMANT</b> Address <b>Mrs. Anna Kaempfe, Perryville, Mo.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Maxillary sinus tumor with cerebral metastases &amp; with</b> DUE TO (b) <b>Maxillary sinus malignant tumor</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Rheumatic Heart Disease</b>						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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <u>July, 1957</u> to <u>8/3/59</u> and last saw him alive on <u>8/3/59</u> Death occurred at <u>8/3/59</u> <u>10:00 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>D. E. McDermott, M.D.</b>				<b>22b. ADDRESS</b> <b>Perryville, Mo.</b>		<b>22c. DATE SIGNED</b> <b>8/4/59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>8-6-59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Immanuel Lutheran</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Perryville Missouri</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Young &amp; Sons Perryville, Mo.</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-5-59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Joe J. Joellner</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0921 6 1 917

**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 Wallace Young

Licensed Embalmer No. 4027

P. O. Address Perryville

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.