

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030136

FILLED VS SEP 8 1959 310

Registration District No. _____ Primary Registration District No. 2058 Registrar's No. 207

STATE FILE NUMBER

UNDEED

1. PLACE OF DEATH a. COUNTY St Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St Charles									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Charles		Length of stay in 1b 2 wks		c. CITY OR TOWN O'Fallon		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St Joseph Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Rural Rt 1		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First John Middle J. Last Meyer				4. DATE OF DEATH Month Aug. Day 29 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 1/1/1894		9. AGE (last birthday) 65		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) St Charles Co.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME William Meyer				13b. MOTHER'S MAIDEN NAME Christine Stenger				14. NAME OF HUSBAND OR WIFE Leona Meyer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 486-14-4447		17. INFORMANT Address Leona Meyer O'Fallon Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pyelonephritis & Uremia										INTERVAL BETWEEN ONSET AND DEATH 50 YRS.			
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)								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 _____ a.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 July 6, 1959 to Aug 29, 1959 and last saw ^{her} him alive on Aug 29, 1959 Death occurred at 9:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Paul L. Rother M.D. (degree or title)						22b. ADDRESS St. Charles, Mo.				22c. DATE SIGNED 9-2-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/2/59		23c. NAME OF CEMETERY OR CREMATORY Assumption Cemetery		23d. LOCATION (City, town, or county) O'Fallon Mo		(State)					
24. FUNERAL DIRECTOR Keithly Funeral Home				ADDRESS O'Fallon Mo		25. DATE RECD. BY LOCAL REG. Sept. 4-59		26. REGISTRAR'S SIGNATURE Maree Wilson					

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 Arthur C. Davis

Licensed Embalmer No. 3155

P. O. Address St Charles

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.