

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011521

FILED VS APR 12 1960

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 2167

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Lawrence</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webb City</b>		Length of stay in 1b <b>one week</b>	c. CITY OR TOWN <b>Mt. Vernon, R.R. #3</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jane Chinn Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>Lee</b> Last <b>Meyer</b>			4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-8-1891</b>	9. AGE (last birthday) <b>68</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Fred Wuellner</b>		13b. MOTHER'S MAIDEN NAME <b>Sabina Kolbe</b>		14. NAME OF HUSBAND OR WIFE <b>John Fred Meyer, dec'd</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>X</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Esther Wormington-Mt. Vernon, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Circulatory Collapse</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 min.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Intestinal Hemorrhage</b>					<b>10 min.</b>	
DUE TO (c) <b>Carcinoma Stomach</b>					<b>History year</b>	
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 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 <b>3-20-60</b> to <b>3-26-60</b> and last saw <sup>her</sup> <del>xxx</del> alive on <b>3-26-60</b> Death occurred at <b>4:15</b> <b>P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>[Signature]</i> (Degree or title)			22b. ADDRESS <b>624 W. Broadway, Webb City, Mo.</b>		22c. DATE SIGNED <b>3-31-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Mar. 29, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Evangelical</b>		23d. LOCATION (City, town, or county) (State) <b>Mt. Vernon Mo.</b>		
24. FUNERAL DIRECTOR <b>Max L. Fossett</b>		ADDRESS <b>Mt. Vernon, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-4-60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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 Max L. Fossett

Licensed Embalmer No. 4252

P. O. Address M. Vernon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.