

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013751

FILED JVS MAR 18 1960 317

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 802 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEMAY</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Length of stay in lb <u>4 DAYS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MARYRIDGE NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>1125 WILMINGTON</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIE EMMA MEYER</u>			4. DATE OF DEATH Month Day Year <u>MARCH 5, 1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/26/1877</u>	9. AGE (last birthday) <u>82</u>	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) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>GERMANY (NAT'L)</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>KARL DOERING</u>		13b. MOTHER'S MAIDEN NAME <u>EMILIE KLOTT</u>	
14. NAME OF HUSBAND OR WIFE <u>WILLIAM J. MEYER (DEC.)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MISS MARIE MEYER, 1125 WILMINGTON, ST. LOUIS</u>		17. ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>5 years</u> <u>10 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerotic Heart Dis.</u>			
DUE TO (c) <u>Atherosclerosis 420.0</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atherosclerotic Nephritis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u>2-16-60</u> to <u>3-5-60</u> and last saw her/him alive on <u>3-1-60</u> Death occurred at <u>12:05 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Eugene Hedele, MD</u>		22b. ADDRESS <u>4971 Chippewa St</u>		22c. DATE SIGNED <u>3-7-60</u>
23a. BURIAL, CREMATION, REBURYAL (Specify)	23b. DATE <u>3/8/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>LEMAY, MISSOURI</u>	
24. FUNERAL DIRECTOR ADDRESS <u>HOFFMEISTER COLONIAL MORTUARY</u> <u>6464 CHIPPEWA STREET, ST. LOUIS, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>3-8-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John Denne*

Licensed Embalmer No. 4194

P. O. Address St. Louis

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.