URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 6 1960 53

Registration District No. _____ Primary Registration District No. 3010 Registrar's No. 349 =60=029863 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH
a. COUNTY Cape Girardeau
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau — Length of stay in Ib 42 hrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION S.E. Mo. Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cape Girardeau
c. CITY OR TOWN New Wells — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) No Street Address — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First ELDA Middle FRIEDA Last MEYR
4. DATE OF DEATH Month Aug. Day 24 Year 1960
5. SEX F
6. COLOR OR RACE W
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 7/2/1911
9. AGE (last birthday) 49
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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (City and state or country) Altenburg, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Louis Gerler
13b. MOTHER'S MAIDEN NAME Anna Lichtenegger
14. NAME OF HUSBAND OR WIFE Albert H. Meyr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Pauline Richter Address New Wells Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ingestion of Paris Green (arsenic) — INTERVAL BETWEEN ONSET AND DEATH 48 hr.
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☒ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Aug. 22-60 to Aug 24 '60 and last saw her/him alive on Aug 23, 1960
Death occurred at 6.55 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Charles F. Wilson M.D. (Degree or title)
22b. ADDRESS 714 Broadway, Cape Girardeau, Mo.
22c. DATE SIGNED 8-25-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 8/26/1960
23c. NAME OF CEMETERY OR CREMATORY New Wells
23d. LOCATION (City, town, or county) New Wells (State) Mo.
24. FUNERAL DIRECTOR McCombs ADDRESS Jackson, Mo.
25. DATE RECD. BY LOCAL REG. Aug. 30-60
26. REGISTRAR'S SIGNATURE Lum Karten

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Irene Dockins

Signature of Student Embalmer

Licensed Embalmer No. 5097

P. O. Address Jackson, M

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