

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 26 1960

8202-60-032604

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8202** STATE FILE NUMBER

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>ST. LOUIS</b>		Length of stay in 1b <b>8 DAYS</b>	a. STATE <b>MISSOURI</b> b. COUNTY
c. FULL NAME OF (IF NOT in hospital, give location) <b>ST. ANTHONY'S HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
		d. STREET ADDRESS <b>3400a HARTFORD</b>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	<b>ADOLPH</b>	<b>P.</b>	<b>MEYER</b>	<b>AUGUST 12, 1960</b>			

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/1877</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOOD SALES</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>		

13a. FATHER'S NAME <b>(1st UNKNOWN) MEYER</b>	13b. MOTHER'S MAIDEN NAME <b>(UNKNOWN)</b>	14. NAME OF HUSBAND OR WIFE <b>ADELINE JOHNSON MEYER</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>488-07-2309</b>	17. INFORMANT <b>ADELINE JOHNSON MEYER, 3400a HARTFORD</b>	Address <b>ST. LOUIS</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Arterio Sclerotic Heart Disease</b>	<b>unk</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized Arteriosclerosis</b>	<b>unk</b>
	DUE TO (c) <b>4200</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Multiple Abscesses of Kidneys</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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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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
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21. I attended the deceased from <b>3/1/59</b> to <b>8/17/60</b> and last saw her alive on <b>8/16/60</b> Death occurred at <b>10:15 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Robert S. Warner MD</b>	(Degree or title)	22b. ADDRESS <b>818 Elm St St Louis MO</b>	22c. DATE SIGNED <b>8/19/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>8/20/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FRIEDENS CEMETERY</b>	23d. LOCATION (City, town, or county) (Style) <b>ST. LOUIS COUNTY, MISSOURI</b>
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24. FUNERAL DIRECTOR <b>HOFFMEISTER COLONIAL MORTUARY</b> <b>616 CHATELAIN STREET ST. LOUIS, MISSOURI</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 19 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 14 1967

**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 Bruce C. Branson

Licensed Embalmer No. 476

P. O. Address St Louis

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.