

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036385

FILED VS. OCT 6 1960

318

1003

9432

STATE FILE NUMBER

NEED

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) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>years</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>904 Canaan Avenue</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>904 Canaan Avenue</b>	
				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>(Clara) Clara</b>			First <b>(Clara)</b> Middle		Last <b>Meisner</b>		DATE OF DEATH <b>September 24, 1960</b>		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-30-1906</b>		9. AGE (last birthday) <b>54</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Julius G. Meusner</b>			13b. MOTHER'S MAIDEN NAME <b>Sophie Drees</b>			14. NAME OF HUSBAND OR WIFE <b>Never Married</b>			
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>none</b>		17. INFORMANT <b>Francis Meusner, 904 Canaan Avenue</b>				

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 <b>6 hrs</b>	
IMMEDIATE CAUSE (a)			<b>Cerebral Hemorrhage</b>	
DUE TO (b)			<b>Arteriosclerosis</b>	
DUE TO (c)			<b>Head injury at 7 years of age</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			<b>331x</b>	
			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 - SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <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 <b>9:24 am</b> to <b>9:25 pm</b> and last saw her <del>xxx</del> <b>alive</b> on <b>9-24-60 am</b>		Death occurred at <b>4:00 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.							

22a. SIGNATURE (Degree or title) <b>W. A. Knight</b>			22b. ADDRESS <b>8201 N Broadway St Louis</b>			22c. DATE SIGNED <b>9-26-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Sept 27 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		

24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Av</b>			25. DATE RECD. BY LOCAL REG. <b>SEP 26 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

*ak*  
*Paul G. Johnson*  
*Sept 19/20/60*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Glenn B. Katz*

Licensed Embalmer No. 373

P. O. Address St. James

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