

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FIRMIN DESLOGE HOSP.		d. STREET ADDRESS (If outside, give location) 2655 RUSSELL BLVD	

3. NAME OF DECEASED (Type or print) First Susanna Middle Meyer Last Meyer			4. DATE OF DEATH Month DEC Day 28 Year 1960		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH *7-7-1882	9. AGE (last birthday) 78	IF UNDER 1 Year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) RACINE WISCONSIN	
12. CITIZEN OF WHAT COUNTRY U-S-A		13a. FATHER'S NAME SEBASTIAN MUELLER		13b. MOTHER'S MAIDEN NAME FRANCES SEIBERT	
14. NAME OF HUSBAND OR WIFE HENRY M MEYER (DECD)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FRANCES EXLER		17. ADDRESS 2655 RUSSELL			

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) Diffuse hemorrhage			24 hrs.
DUE TO (b) Shock			
DUE TO (c) Blak. lower extremity ischemia			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
744.2			

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.)
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 **12-26-60** to **12-28-60** and last saw her/him alive on **12-28-60**
 Death occurred at **13⁰⁰a** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Vallie A. Willman, M.D.	(Degree or title)	22b. ADDRESS Firmin Desloge Hospital	22c. DATE SIGNED 12-29-1960
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC 31 1960	23c. NAME OF CEMETERY OR CREMATORY ST. PETER & PAUL CEM.	23d. LOCATION (City, town, or county) ST. LOUIS	(State) MO.
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois		25. DATE RECD. BY LOCAL REG. DEC 29 1960	26. REGISTRAR'S SIGNATURE Coal Smith, M.D.	

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

Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Jrs

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