

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048290

STATE FILE NUMBER

FILED VS JAN 5 1961 317

Registration District No. _____ Primary Registration District No. 500 Registrar's No. 3716

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ill.</u> b. COUNTY _____				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		Length of stay in 1b <u>1 Day</u>		c. CITY OR TOWN <u>Hoffman</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Osteopathic</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Renata</u> Middle <u>Caroline</u> Last <u>Meyer</u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> , Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-1882</u>	9. AGE (last birthday) <u>78</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>Artist</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Hoffman, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Karl A. Meyer</u>			13b. MOTHER'S MAIDEN NAME <u>Marie Anna Kulms</u>			14. NAME OF HUSBAND OR WIFE <u>None,</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>492-05-9751</u>		17. INFORMANT <u>Eleanor Christine Meyer Hoffman, Ill.</u>			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>Respiratory Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sec.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage</u>						<u>1 day</u>		
DUE TO (c) <u>Generalized Arteriosclerosis</u>						<u>Yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiac Decompensation - Respiratory acidosis - Senility</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 _____ 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 <u>Dec 22, 1960</u> to <u>Dec 23, 1960</u> and last saw her alive on <u>Dec 23, 1960</u> Death occurred at <u>9:05 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>William D. McTeague, J. M.D.</u>				22b. ADDRESS <u>7811 Carondelet Chicago, Ill.</u>		22c. DATE SIGNED <u>12/23/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hoffman Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lake Township, County, Ill.</u>				
24. FUNERAL DIRECTOR <u>Queen-Boggs Centralia Ill.</u>				25. DATE RECD. BY LOCAL REG. <u>12-24-60</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy, M.D.</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 4 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 James R. Chap

Licensed Embalmer No. 45

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.