

# PRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048350

FILED **JAN 5 1961** 317

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3787 STATE FILE NUMBER

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Ferdinand Twp</b> Length of stay in lb <b>6 wks</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>HALLSFERRY NURSING HOME</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> c. CITY OR TOWN <b>St. Ferdinand Twp</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>12465 Old Hallsferry</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ANNA</b> Middle Last <b>MEYER</b>			<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>28th</b> Year <b>1960</b>				
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2/27/68</b>	<b>9. AGE</b> (last birthday) <b>92</b>	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HR</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis Co., Mo</b>			
<b>13a. FATHER'S NAME</b> <b>Henry Holtmann</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Wilhelmina Wolfs</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Charles W. Meyer</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> Address <b>Emma Loesing, 12465 Old Hallsferry</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 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)					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>unknown</b>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour _____ s.m. _____ p.m. _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b> <b>STATE</b>			
<b>21. I attended the deceased from</b> <b>Nov 7, 1960</b> to <b>Dec 28, 1960</b> and last saw her alive on <b>12/27/60</b> Death occurred at <b>8:15A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>Lewis Littenmann MD</b>			<b>22b. ADDRESS</b> <b>8231 Clayton Rd (17)</b>		<b>22c. DATE SIGNED</b> <b>12/30/60</b> (State)		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>		<b>23b. DATE</b> <b>12/31/60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Salem Ev. Lutheran Cemetery</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>12-30-60</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>John C. Murphy M.D.</i>			

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 Stanley H. Aiso

Licensed Embalmer No. 419

P. O. Address St. Louis

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