

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002760

Registration District No. 316 Primary Registration District No. \_\_\_\_\_ Registrar's No. 43

STATE FILE NUMBER

FILED VS FEB 14 1961

1. PLACE OF DEATH a. COUNTY <u>ST FRANCIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. GENEVIEVE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST FRANCIS TWP FARMINGTON-RURAL</u> Length of stay in 1b <u>14 DAYS</u>		c. CITY OR TOWN <u>ST. GENEVIEVE</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>MINERA AREA HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>12242</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>THERSIA MARY MEYER</u>			4. DATE OF DEATH Month Day Year <u>FEB 4 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/1926</u>	9. AGE (last birthday) <u>68</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>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>ST. GENEVIEVE MO U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>LAURENCE BARR</u>		13b. MOTHER'S MAIDEN NAME <u>CATHERINE SCHUBERT</u>		14. NAME OF HUSBAND OR WIFE <u>JOSEPH C. MEYER</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.		17. INFORMANT Address <u>Herman Meyer, Sr. Genevieve Mo</u>	

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) <u>Hepatic Coma</u>		<u>12 h</u>
DUE TO (b) <u>Debility and Inanition</u>		<u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>Laenneo's Cirrhosis of the liver</u>		<u>indefinite</u>
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 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>Sept, 1960</u> to <u>Feb 4, 1961</u> and last saw her alive on <u>Feb 3, 1961</u> Death occurred at <u>700</u> <u>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>Reed E. Marts D.O.</u>		22b. ADDRESS <u>St. Genevieve, Mo</u>		22c. DATE SIGNED <u>2-5-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALLE SPRING</u>	23d. LOCATION (City, town, or county) (State) <u>ST. GENEVIEVE MO</u>	

24. FUNERAL DIRECTOR ADDRESS <u>See C. Baskie, Sr. Genevieve Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 5, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Ether A. Lindloff</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDED  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

FEB 21 1961

ALSO SEE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Adrian J. Ehler

Licensed Embalmer No. 4740

P. O. Address St. Genevieve

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.