

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-006080  
STATE FILE NUMBER

AMENDED FILED VS MAR 6 1961 Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 70

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Benton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sedalia</b>	Length of stay in lb <b>2 Mos</b>	c. CITY OR TOWN <b>Cole Camp</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bothwell Hospital</b>	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 checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>J</b> Last <b>Meyer</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>28</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-14-1891</b>	9. AGE (last birthday) <b>69</b>	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) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Mt Hulda Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>Eugene Kreisel</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Wenig</b>		14. NAME OF HUSBAND OR WIFE <b>Rudolph B Meyer</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. -----	17. INFORMANT Address <b>Herbert Meyer Cole Camp Mo</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
IMMEDIATE CAUSE (a)	<b>Acute Intestinal Hemorrhage</b>	<b>2 1/2 Hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hepatic Renal Failure</b>	<b>10 Days</b>
	DUE TO (c) <b>Surgery for Common Bile Stone followed by Cholangitis</b>	<b>10 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Warts condylomata, Bicuspid Aortic Atherosclerosis</b>		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 <b>1954</b> to <b>2/28/61</b> and last saw her alive on <b>2/28/61</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <b>Thomas J. Winters, M.D.</b>		(Degree or title)	22b. ADDRESS <b>Sedalia, Mo.</b>	22c. DATE SIGNED <b>3/1/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-2-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Cole Camp Mo</b>
24. FUNERAL DIRECTOR <b>E L Eickhoff Cole Camp Mo</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3/2/1961</b>	26. REGISTRAR'S SIGNATURE <b>Frances Shelby</b>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 E. L. Eckhardt

Licensed Embalmer No. 730

P. O. Address oak Camp Ill

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.