

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri 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 City Hospital		d. STREET ADDRESS (If outside, give location) 4519 Louisiana Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Arthur Meyer			4. DATE OF DEATH Month Day Year Oct 25 1961
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/19/34
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Laclede Gas Co	9. AGE (last birthday) 27
13a. FATHER'S NAME Arthur W Meyer		13b. MOTHER'S MAIDEN NAME Helen Hickman	12. CITIZEN OF WHAT COUNTRY U S
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. ---	17. INFORMANT Address Carol Ann Meyer 4519 Louisiana
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis resulting from DUE TO (b) gunshot wound, self inflicted in DUE TO (c) home on 10/23/61 suicide PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Do not refer to the terminal disease condition given in PART I (a))			INTERVAL BETWEEN ONSET AND DEATH " 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 type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 976x see above	
20c. TIME OF INJURY? Hour a.m. p.m. 10-23-61		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION COUNTY STATE St Louis, Mo	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ 6:25 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Helen L. Taylor, Coroner		22b. ADDRESS 1300 Clark Ave.	22c. DATE SIGNED 10-25-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/27/61	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St Louis County Mo
24. FUNERAL DIRECTOR Address Moydell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. OCT 25 1961	26. REGISTRAR'S SIGNATURE Carol Ann Meyer

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 Halley F. Joelle Jr

Licensed Embalmer No. 7950

P. O. Address St Louis

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.