

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

8325-62-032704  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED AUG 31 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist</b>		d. STREET ADDRESS (If outside, give location) <b>2221 Arsenal St.</b>	
3. NAME OF DECEASED (Type or print) First <b>MAMIE</b> Middle <b>-</b> Last <b>MEIER</b>		4. DATE OF DEATH Month <b>Aug</b> Day <b>25</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/27/91</b>
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>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo</b>
13a. FATHER'S NAME <b>Fred Seebach</b>		13b. MOTHER'S MAIDEN NAME <b>Louisa Ruder</b>	14. NAME OF HUSBAND OR WIFE <b>Joseph H. Meier, Jr.</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. <b>None</b>	17. INFORMANT <b>2221 Arsenal st. Joseph H. Meier, Jr.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>AMYOTROPHIC LATERAL SCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Jan, 1960</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>3561</b>			
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 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 <b>11-3-60</b> to <b>8-25-62</b> and last saw her <sup>her</sup> <del>from</del> alive on <b>8-25-62</b> Death occurred at <b>6:00 a.m.</b> on the date stated above with <sup>the</sup> <del>the</del> <sup>best</sup> <del>best</del> of my knowledge, from the causes stated. <b>DRENNAN BAILEY, M.D.</b>			
22a. SIGNATURE (Degree or title) <i>Drennan Bailey M.D.</i>		22b. ADDRESS <b>6356 CLAYTON ROAD ST. LOUIS 17, MO.</b>	22c. DATE SIGNED <b>8/25/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Aug 28, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Lucas Cem</b>	23d. ADDRESS (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Kutis Funeral Home, Inc 2906 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 27 1962</b>	26. REGISTRAR'S SIGNATURE <i>Keon Smith, M.D.</i>

**AUG 27 1962**

50. Air ... Building 1356 Clayton Rd. Nri 7-3834

**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 Eleanora Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grassi

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.