

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-020995

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 167

FILED MAY 17 1963

VS 300
Rev. 4/59

1 0808
2 0710
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4 0
5 0
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7 2
8 0
9 6924A
10 8
11 1-2
12 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Length of stay in 1b <u>4 days</u>	c. CITY OR TOWN <u>Stover</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 mile South</u>

3. NAME OF DECEASED (Type or print) First <u>Chaus</u> Middle <u>MEYER</u> Last <u>MEYER</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>14</u> Year <u>1963</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 13, 1875</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (City and state or country) <u>FARGO GERMANY</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Theas Meyer</u>		13b. MOTHER'S MAIDEN NAME <u>MARIE PAPE</u>		14. NAME OF HUSBAND OR WIFE <u>Never Married</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>no</u>			16. SOCIAL SECURITY NO. <u>225</u>		17. INFORMANT <u>Elmer Meyer Stover Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u>		
DUE TO (b) <u>Septicemia</u>		<u>4 Days</u>
DUE TO (c) <u>Cellulitis - Both legs</u>		<u>1 Week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Fracture - Head of Femur</u>		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 Month; Day, Year a.m. p.m.		20f. CITY, TOWN, OR LOCATION <u>Stover, Mo.</u> COUNTY STATE	
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.)	
21. I attended the deceased from <u>7/7/62</u> and last saw her alive on <u>5/13/63</u> Death occurred at <u>11:37 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. U. Kappa D.O.</u> (Degree or title)		22b. ADDRESS <u>Stover, Mo.</u>	
22c. DATE SIGNED <u>5/15/63</u> (State)		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S CEMETERY</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAY 17, 1963</u>	
24. FUNERAL DIRECTOR <u>SCRIVNER-STEVINSON</u> ADDRESS <u>Stover, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 15, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u> <u>A. Anderson</u>			

USE BLACK INK
OR
TYPEWRITER RIBBON

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 James P. Scenic

Licensed Embalmer No. 4880

P. O. Address Wrentham, Mass.

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.