

MAY 25 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

Dr. Bud Meyer
14392
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1. PLACE OF DEATH

County *Franklin* Registration District No. *318*
Township *Franklin* Primary Registration District No. *2071*
City *Murfreesboro* (No. *St. John's Hospital*) Registered No. *311*
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. *1851 no man* Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 13 1863*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 2 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Fishery*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bellville Ill.*

10. NAME OF FATHER *Ben J. Martin*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Quincy Ill.*

12. MAIDEN NAME OF MOTHER *Opala Johnson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Quincy Ill.*

14. INFORMANT (Address) *Dr. Bud Meyer
Franklin Mo.*

15. FILED *4-16-29* *For Sharp* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 11 1929*

17. I HEREBY CERTIFY That I attended deceased from *Feb 28* 19*29* to *April 11* 19*29*.
that I last saw him alive on *April 11* 19*29*; and that death occurred, on the date stated above, at *11:00* a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

gall stones
Carcinoma gall bladder
4 yr. (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

446 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *yes*; DATE OF *Feb 28-29*
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *microscopic*
(Signed) *Arthur Meyer*, M.D.

(Address) *Murfreesboro Mo.*
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Meyer *April 11 1929*

20. UNDERTAKER ADDRESS
W. H. Springer

23 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. THIS IS A PERMANENT RECORD

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