

Registration District No. **1003** Primary Registration District No. _____

1. PLACE OF DEATH: **1**
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Barnard Skin And Cancer Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 Months**
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: **1**
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **6**
(d) Street No. **4812 St. Louis Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Andrew L. Meyer** **(6-10)**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mary Meyer** 6. (c) Age of husband or wife if alive **59** years
7. Birth date of deceased **April 28th 1882**
(Month) (Day) (Year)

8. AGE: Years **77** Months **7** Days **20**
If less than one day _____ hr. _____ min.

9. Birthplace **Belleville Illinois**
(City, town, or county) (State or foreign country)
10. Usual occupation **Retired Machinist**

11. Industry or business _____
12. Name **Unknown** ?
13. Birthplace **Unknown** ?
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown** ?
15. Birthplace **Unknown** ?
(City, town, or county) (State or foreign country)

MOTHER FATHER
16. (a) Informant's own signature **Guly Hartman**
(b) Address **4812 St. Louis Ave**
17. (a) **Burial** (b) Date thereof **12/20/39**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **News Bethlehem**
Stroot - Carroll
18. (a) Signature of funeral director _____
(b) Address **4600 Natural Bridge Ave**
19. (a) **DEC 19 1939** (b) **J. B. Budeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **17**
year **1939** hour **4** minute **15p** M.

21. I hereby certify that I attended the deceased from **Feb.** 19**39** to **12-17**, 19**39**
and that death occurred on the date and hour stated above.
that I last saw him alive on **12-17**, 19**39**

Immediate cause of death **Cerebral hemorrhage** Duration **24 hrs.**
Due to **Arteriosclerosis** **1 + yrs.**

Other conditions (Include pregnancy within 3 months of death) **88**
Major findings: Of operations **X**
Of autopsy **X**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **X**
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place) (e) Means of injury _____
While at work? **Samuel Collins** (M. D. or other)
23. Signature **Samuel Collins** Address **Barnard Hosp.** Date signed **12-19-39**

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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. 2265-

P. O. Address.....

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 this body is not embalmed, above space should be left blank.