

Registration District No. 755

Primary Registration District No. 5796^c

Registrar's No.

1. PLACE OF DEATH:

(a) County St Charles(b) City, or town Rural

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

In this community Life
years, months or days (Specify whether)3. (a) PRINT FULL NAME William Meyer3. (b) If veteran, name war _____ 3. (c) Social Security No. None4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Linda Meyer 6. (c) Age of husband or wife if alive 46 years7. Birth date of deceased Sept 30 1889
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
50 7 17 hr. 0 min.9. Birthplace St Charles Co
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business _____

12. Name Henry Meyer13. Birthplace St Charles Co
(City, town, or county) (State or foreign country)14. Maiden name Lizzie Meyer15. Birthplace St Charles Co
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Linda Meyer(b) Address Matson Mo.17. (a) Burial Augusta (b) Date thereof May, 19, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Augusta, Mo.18. (a) Signature of funeral director Marion Munday(b) Address Hamburg Mo.19. (a) 5/18/1940 (b) Olson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Charles(c) City or town Rural

(If outside city or town limits, write "RURAL")

(d) Street No. Matson Mo
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17
year 1940 hour 2 minute 30 A. M.21. I hereby certify that I attended the deceased from May 14
1940, to May 17, 1940that I last saw him alive on May 17, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Cerebral Hemorrhage
arteriosclerosis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(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? _____

While at work _____ (Specify type of place)
(e) Means of injury _____23. Signature Valorn Day (M. D. or other)Address Augusta Mo Date signed 5/18/40

Duration

3 days
5760

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically

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 Morris M. Munday

Licensed Embalmer No. 2461

P. O. Address Hamlet, N.C.

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.