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23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

27237
State File No. 7133
Registrar's No.

Registration District No. 791

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Erline Meyer *LOM*

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex Female race White

5. Color or race _____

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Leo

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased March 10 1905
(Month) (Day) (Year)

8. AGE: Years 35 Months 5 Days 11 If less than one day _____
hr. min.

9. Birthplace Bloomington Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Robert Ralmondine

13. Birthplace St. Genevieve Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Overgo

15. Birthplace St. Genevieve Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. S. Meyer

(b) Address St. Genevieve, Mo.

17. (a) Removal (b) Date thereof 8-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Genevieve, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. AUG 23 1940 (Date received local registrar)
(b) [Signature] (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____

(c) City or town ST. GENEVIEVE *MR*
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21
year 1940 hour 9 minute pm. M.

21. I hereby certify that I attended the deceased from August 15 1940 to Aug. 21 1940
that I last saw her alive on August 21 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Post-operative Bronchitis -
Pneumonia
Due to General Peritonitis

Due to Subtotal Pulmonary
resected right pyosalpinx
non malignant
Other conditions non malignant
(Include pregnancy within 3 months of death)

Major findings: resected right pyosalpinx
Of operations General Peritonitis
Of autopsy _____

Duration	PHYSICIAN
<u>2 days</u>	_____
<u>1 week</u>	_____
<u>1 week</u>	_____

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) (or) Means of injury _____

23. Signature Walter M. Smith (M. D. or other) yes
Address 4145 S. Grand Date signed 8/23/40

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.