

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36000

State File No. _____
Registrar's No. _____

Registration District No. 969 Primary Registration District No. 5877

1. PLACE OF DEATH:
(a) County PERRY
(b) City or town SCHNURBUSCH
(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 2
In this community 78-9-27 (Specify whether years, months or days)

3. (a) PRINT FULL NAME HUGO JOSEPH MEYER
8. (b) If veteran, name war _____ 8. (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 ANNA KATHERINE SCHNURBUSCH 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased DECEMBER 17, 1861
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>9</u>	<u>27</u>	hr. _____ min.

9. Birthplace PERRY COUNTY MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____
12. Name HUGO JOSEPH MEYER
13. Birthplace GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name BARBARA FINDER
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature L. J. Meyer
(b) Address Perryville, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 17, 1940
(Month) (Day) (Year)
(c) Place: burial or cremation SCHNURBUSCH CATHOLIC CEM.

18. (a) Signature of funeral director Bey Funeral Home
(b) Address PERRYVILLE, MO.

19. (a) 10-17-1940 (Date received local registrar) (b) Bey Halter (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County PERRY
(c) City or town SCHNURBUSCH
(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 October day 14th year 1940 hour 8 minute 35 P.M.
21. I hereby certify that I attended the deceased from October 6, 1940 to October 14, 1940
that I last saw him alive on October 13, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death <u>Hypostatic pneumonia</u>	Duration <u>12 hours</u>
Due to <u>Chronic myocarditis</u>	<u>10/2/40 +</u>
Due to _____	_____
Other conditions <u>Left Hemiplegia</u> (Include pregnancy within 3 months of death)	<u>2 mos.</u>
Major findings: Of operations <u>none</u> Of autopsy <u>none</u>	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) _____
(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? 56
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Barnard T. Koon (M. D. or other) MD
Address Perryville, Mo. Date signed 10/16/40

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

Rev. 6-17-39 1 X1951 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.

92c

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.....

Le Roy J. Schindler....., Registered Apprentice No. *231*
working under my personal supervision.

Signed *Albert H. Bey*.....

Licensed Embalmer No. *3866*.....

P. O. Address *Perryville, Mo.*.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36000**

Registration District No. **969**

Primary Registration District No. **3877**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Perry
 (b) City or town Union, T. P.
(If outside city or town limits, write "RURAL" and name of township)
 (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 _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Hugo Joseph Mayer
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 78 Months 9 Days 27
If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(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 10 day 19
 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above,
 Immediate cause of death Hypostatic pneumonia
Chronic myocarditis

Due to _____
 Due to _____
 Other conditions Left Hemiplegia
(Include pregnancy within 3 months of death)
Cerebral Hemorrhage
 Major findings:
 Of operations _____
 Of autopsy 92C

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?
(Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature Bernard T. Koon (M. D. or other) M.D.
 Address Perryville, Mo. Date signed 12/19/40

SUPPLEMENTAL

Duration 10/19/40
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

