

No. 2
4-13-40
-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9427**
2837
Registrar's No.

Registration District No. **791**
Primary Registration District No.

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
In this community..... **0** years, months or days)

3. (a) PRINT FULL NAME **Meyer, Mr. Fred**
3. (b) If veteran, name war..... **Unknown**
3. (c) Social Security No. **None**

4. Sex **Male** race **White**
5. Color or race.....
6. (a) Single, widowed, married, divorced, **widowed**
6. (b) Name of husband or wife **Cora Chandler**
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **April 4 1868**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	11	24	hr. min.

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

10. Usual occupation **Laborer**

11. Industry or business.....

MOTHER FATHER
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)

16. (a) Informant **Fred Meyer**
(b) Address **Ste. Genevieve, Mo.**

17. (a) **Burial** (b) Date thereof **3/31/41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Ste. Genevieve, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Ave**

19. (a) **APR 31 1941** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Ste. Genevieve**
(c) City or town **Ste. Genevieve**
(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.? **1** years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **28**
year **1941** hour **about 9:30** minute **A** M.
21. I hereby certify that I attended the deceased from **May 20**
1941 to **May 28**, 19**41**
that I last saw **him** alive on **May 28**, 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Stomach**
Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death) **H/O**

Major findings: Of operations **None**
Of autopsy **Carcinoma of Stomach**

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) (Means of injury)
23. Signature **[Signature]** (M. D. or other)
Address **[Signature]** Date signed **MAY 4-41**

Duration **> about 2 yrs**
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

0
7
9

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

Guy W. Wilkinson

Licensed Embalmer No.....

3575

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, fact should be so stated above.