

No. 2
1-4-41
5-17-39
1-1-41

FILED SEP 17 1941
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. **26790**
Registrar's No. **6582**

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:
5519 THRUSH AVE
(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) **1**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County _____
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **5519 THRUSH AVE**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **ROBERT MEYER**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **JUNE - 14 - 1941**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 39 hr. min.

9. Birthplace **ST. LOUIS MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **NIL**

11. Industry or business _____

MOTHER FATHER { 12. Name **ROBERT MEYER**
13. Birthplace **ST. LOUIS MO**
(City, town, or county) (State or foreign country)
14. Maiden name **RUTH MCGRAW**
15. Birthplace **ST. LOUIS MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert Meyer**
(b) Address **5519 Thrush ave**

17. (a) **BURIAL** (b) Date thereof **8-13-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MEMORIAL PARK**

18. (a) Signature of funeral director **Walter H. Kelly**

(b) Address **2416 N. Taylor ave**

19. (a) **AUG 12 1941** (b) **J. J. Zwick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **11** day **August**
year **1941** hour **9:15** minute **P** 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 _____ Duration _____

Suffocation
When he Crawled between
Pillow and Mattress
Due in his buggy at his
Home 5519 Thrush ave

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

Major findings:
Of operations _____
Of autopsy _____

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) **Accident**
(b) Date of occurrence **8/11/41**
(c) Where did injury occur? **at home** (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home (Specify type of place)
While at work? _____ (c) Means of injury _____

23. Signature **Thomas F. Calloway** (M. D. or other)
Address **Deputy Coroner** Date signed **8/14/41**

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 *Clement McNearf*

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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.