

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED OCT 2 - 1943 18  
Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 8475

1. PLACE OF DEATH:

(a) County .....  
(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mo. Baptist Hospital.  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution 0  
(Specify whether

In this community  
years, months or days)

3. (a) PRINT FULL NAME Infant Meyers

3. (b) If veteran, name war. Nil 3. (c) Social Security No. Nil

4. Sex Boy 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 Sept. 22 - 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
2 hr. 15 min.

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

10. Usual occupation Infant

11. Industry or business

12. Name Cletus B. Meyers

13. Birthplace Oslen Allen Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Thelma S. Cardin

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

16. (a) Informant Mo. Baptist Hospital

(b) Address 919 N. Taylor

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/43  
(Month) (Day) (Year)

(c) Place: burial or cremation Festus, Missouri.

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

(b) Address 4700 Washington Blvd.

19. (a) SEP 24 1943 (Date received local registrar) (b) J.F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson  
(c) City or town Festus Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 725 Cleveland. 050  
(If rural, give location)  
(e) Citizen of foreign country? ..... (Yes or No) 1  
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 22  
year 1943 hour 11:30 minute A M.

21. I hereby certify that I attended the deceased from Sept 22  
1943 to Sept 22 1943  
that I last saw him alive on Sept 22, 1943, 1943  
and that death occurred on the date and hour stated above:

Immediate cause of death  
Schönborn Achondroplasia  
Dwarf with Hydrocephalus

Due to The abnormality gradually developed from start of embryonic life. Gestation of about 12 months.  
Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations 157  
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 5  
23. Signature E.P. Beckenridge M.D. (M. D. or other)  
Address St. Louis Mo. Date signed 9/23/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**NO EMBALM**

**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.....

*J. H. Hopper, Inc.*

Licensed Embalmer No.....

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.**