

FILED AUG 29 1946

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2223

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town 4373 W. PINE
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
STONE NURSING HOME
(If not in hospital or institution, give street number or location)

(d) Length of stay: 4373 W. PINE 2 MONTHS
In hospital or institution (Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Louise Meyer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased OCTOBER 17 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68 10 5 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name ERNEST EHLE

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

14. Maiden name LUDWICKA CHIKOLA

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

16. (a) Informant ARTHUR MEYER

(b) Address 2628 ANN

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 24 1946
(Month) (Day) (Year)

(c) Place: burial or cremation TRINITY LUTHERAN

18. (a) Signature of funeral director [Signature]

(b) Address 2906 GRAVOIS

19. (a) AUG 29 1946 (Date received local registrar)
[Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS

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

(d) Street No. 2907 PENNSYLVANIA 9
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22
year 1946 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from May
1-46, 19____ to Aug 15, 1946
that I last saw her alive on Aug 15 1946, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Carcinoma of Rectum?

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 5 months of death)

Ho

Major findings: Calosclermy

Of operations May 20-46

Of autopsy _____

Duration _____

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury 0

23. Signature [Signature] (M. D. or other)
Address 4615-50th Date signed 8/23/46

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

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..... *David Van Tossan.*

Licensed Embalmer No. *4242*

P. O. Address. *2906 Grovni*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept
Registrar's No. 7323

Registration District No. 218 Primary Registration District No. 1003

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:

(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

Louise Meyer

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

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

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

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

10. Usual occupation at home

11. Industry or business

MOTHER FATHER }
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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Aug Day 22
year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
to....., 19.....
that I last saw him..... and on....., 19.....
and that death occurred on the date and hour stated above.
(Immediate cause of death.....)

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

Duration.....
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?
While at work?..... (Specify type of place) (c) Means of injury.....
23. Signature..... (M. D. or other)
Address..... Date signed.....

SUPPLEMENTARY

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

28891