

DEPARTMENT OF HEALTH - STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE DEATHS
FILED SEP 16 1946 STANDARD CERTIFICATE OF DEATH

State File No. **32015**
Registrar's No. **2768**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County **ST. LOUIS MO**
(b) City or town **ST. LOUIS MO**
(c) Name of hospital or institution: **BETHESDA HOSPITAL**
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME **JOHN M. MESSMER**
3. (b) If veteran, name war _____
3. (c) Social Security No. **489-07-1467**

4. Sex **MALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **GERTUDE** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **AUGUST 26 1874**
(Month) (Day) (Year)

8. AGE: Years **72** Months **-** Days **17** If less than one day _____ hr. _____ min.

9. Birthplace **AUSTRIA** (City, town, or county) (State or foreign country) **4**

10. Usual occupation **RETIRED**

11. Industry or business **FALSTAFF BREWERY**

MOTHER FATHER

12. Name **MATTHEW MESSMER**

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

14. Maiden name **MARGARET SEITZ**

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

16. (a) Informant **SUSAN KIEFER**

(b) Address **4472 ITASKA**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **Sept. 10 1946**
(Month) (Day) (Year)

(c) Place: burial or cremation **Old S.S. Peter & Paul**

18. (a) Signature of funeral director **Thos. Curtis & Son**
(b) Address **2906 GRAVOIS**

19. (a) **SEP 9 1946** (Date received local registrar) (b) **J. J. Brebeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County _____
(c) City or town **LESLIE** (If outside city or town limits, write "RURAL") **NR**
(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 **Sept.** day **7** year **1946** hour **7** minute **A.M.**

21. I hereby certify that I attended the deceased from **Sept 4 - 7 1946** to **Sept 7 1946**
that I last saw him alive on **Sept 6 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction**
Cardiovascular disease

Due to **Nephritis**

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

Major findings: Of operations _____

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 _____

23. Signature **Lo. Rubin** (M. D. or other) _____
Address **1840 California** Date signed **9/7/46**

Duration **1 yr**
1 yr
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 Sue Fossan

Licensed Embalmer No.....

4242

P. O. Address.....

2906 Harrison Ave

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.