

No. 2
5-43
5-17-39
X388571

FILED MAR 19 1948

Registration District No. **56**

Primary Registration District No. **4080**

1. PLACE OF DEATH:
 (a) County **Sattoli**
 (b) City or town **Norborne, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
601 South Elm
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community **10 Years**

3. (a) PRINT FULL NAME **Mrs. Anna F. 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 **Married**
 6. (b) Name of husband or wife **Albert Meyer**
 6. (c) Age of husband or wife if alive **46** years
 7. Birth date of deceased: **June 25 1903**
(Month) (Day) (Year)

8. AGE: Years **43** Months **8** Days **15**
 If less than one day: _____ hr. _____ min.

9. Birthplace **Emma Mo.**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Housewife**

MOTHER FATHER

11. Industry or business _____
 12. Name **Henry W. Stegemann**
 13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)
 14. Maiden name **Alvina Sass**
 15. Birthplace **Emma Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Albert Meyer**
 (b) Address **Norborne Mo.**
 17. (a) **Burial** (b) Date thereof **3/13/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ridge Park Cem. Marshall, Mo.**
 18. (a) Signature of funeral director **J. Leahy**
 (b) Address **74 Marshall Ave.**
 19. (a) **4-10-48** (b) **Eileen Berniston**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Carroll 17**
 (c) City or town **Norborne Mo** **2**
(If outside city or town limits, write "RURAL")
 (d) Street No. **601 So. Elm** **0**
(If rural, give location)
 (e) Citizen of foreign country? **No** **0**
(Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3-10** day _____
 - year **1948** hour **4** minute **45** P.M.
 21. I hereby certify that I attended the deceased from **12-2-47**
 _____, 19**47**, to **3-10-** 19**48**
 that I last saw **her** alive on **3-10-48** _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Leucemia** ✓
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Duration

2 1/2 years

PHYSICIAN

Major findings:
 Of operations _____
 Of autopsy _____

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)
 (e) Means of injury **0**
 23. Signature **B. E. Cole** (M. D. or other) _____
 Address **Norborne Mo** Date signed **3-10-48**

ADDITIONAL INFORMATION

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 3-18-48

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. L. L. Summary
Licensed Embalmer No. 22357

P. O. Address Marshall, Mo

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.

State File No. April
Registrar's No. _____

Registration District No. 56 Primary Registration District No. 4080

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

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Paris
(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 Anna F. 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 m

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

7. Birth date of deceased June 25 1903
(Month) (Day) (Year)

8. AGE: Years 43 Months 8 Days _____ If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 March Day 10 Year 1948 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to Carcinoma of uterus 3 years

Due to _____

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) _____

(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 Be... (M. D. or other)

Address 1107... (M.D.) Date signed 3-7-48

SUPPLEMENTARY

1945
1000