No. 200
10.48

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

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10412

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2161

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1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5340 Delor St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Mo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 5340 Delor St.

3. NAME OF DECEASED (Type or Print)
a. (First): Oscar
b. (Middle): H.
c. (Last): MEYER

4. DATE OF DEATH (Month) (Day) (Year): Mar. 8 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 2, 1892
9. AGE (In years last birthday): 57 — If under 1 year: Months 1, Days 6; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Traffic Manager
10b. KIND OF BUSINESS OR INDUSTRY: Barnard Staty. Co.
11. BIRTHPLACE (State or foreign country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Henry F. Meyer
13b. MOTHER'S MAIDEN NAME: Ida Beinert
14. NAME OF HUSBAND OR WIFE: Anna Meyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War 1
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Anna Meyer — **ADDRESS**: 5340 Delor St.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphoma (mediastinum) — INTERVAL BETWEEN ONSET AND DEATH: Aug. 1948

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 477
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-23, 1948, *to* 3-6, 1949; *that I last saw the deceased alive on* 3-6, 1949, *and that death occurred at* 5:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Eugene H. Edele M.D.
23b. ADDRESS: 4971 Chippewa St.
23c. DATE SIGNED: 3-8-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Mar. 10, 1949
24c. NAME OF CEMETERY OR CREMATORY: Bellefontaine Cem.
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG.: MAR 8
REGISTRAR'S SIGNATURE: J. B. Lassiter
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Kriegshauser 4228 S. Kingshighway Bl.

(Licensed Embalmer's Statement on Reverse Side)

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 _____

_____, Student Embalmer No. _____

working under my personal supervision.

Signed Richard W. Stovesand

Signed _____
Student Embalmer

Licensed Embalmer No. 4007

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.