

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42769

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10944

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place) 11		d. STREET ADDRESS (If rural, give location) 3122 MAGNOLIA	
d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL			

3. NAME OF DECEASED (Type or Print) EDERHART - MEYEROSE	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) DEC. 19 1949
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAR. 28 1862	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 21	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER	10b. KIND OF BUSINESS OR INDUSTRY PAINT CO.	11. BIRTHPLACE (State or foreign country) GERMANY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME HENRY MEYEROSE	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE ELIZABETH MEYEROSE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NINE	17. INFORMANT'S SIGNATURE OR NAME ELIZABETH MEYEROSE	ADDRESS 3122 MAGNOLIA
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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		INTERVAL BETWEEN ONSET AND DEATH 1 Day years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Infection of Heart		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Roch's Phenol's DUE TO (c) Acute Rheumatic Fever		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOBSEY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Miss Mo
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H/IX
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22. I hereby certify that I attended the deceased from **Sept 1, 1949** to **Dec 17, 1949**, that I last saw the deceased alive on **Dec 17, 1949**, and that death occurred at **3:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Lutz Beck	23b. ADDRESS 1504 P. General	23c. DATE SIGNED 9.20.49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE DEC. 22 1949	24c. NAME OF CEMETERY OR CREMATORY PARK LAWN CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE DEC 20 1949	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Ratis	ADDRESS 2906 Harris
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1504 P. Johnson
Pr 1600
3-4 PM

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 _____

working under my personal supervision.

Student Embalmer No.

Signed James C Hill

Signed.....
Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 Graves

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.