

FILED SEP 1 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28531

State File No. 7398

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Missouri		c. LENGTH OF STAY (in this place) 25 OR TOWN St. Louis 2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hosp. # 1		d. STREET ADDRESS (If rural, give location) 119a So. Broadway	
3. NAME OF DECEASED (Type or Print) a. (First) Julius b. (Middle) c. (Last) Meyer		4. DATE OF DEATH (Month) (Day) (Year) August 18 1951	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 12-17-1869
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME William Meyer	
13b. MOTHER'S MAIDEN NAME Louisa		14. NAME OF HUSBAND OR WIFE	
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.	
17. INFORMANT'S SIGNATURE OR NAME Medical Record		ADDRESS	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal obstruction; peritonitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Strangulated internal hernia DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 560.4			
22. I hereby certify that I attended the deceased from 8/17/51 , 19___, to 8/18/51 , 19___, that I last saw the deceased alive on 8/18/51 , 19___, and that death occurred at 7:30 p. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) William A. Gibson, M.D.		23b. ADDRESS 5560 PERSHING - ST. LOUIS, MO.	
23c. DATE SIGNED 8/19/51			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 8-22-51	
24c. NAME OF CEMETERY OR CREMATORY MT. EVERGREEN		24d. LOCATION (City, town, or county) (State) Millstadt, Ill.	
DATE REC'D BY LOCAL REG. AUG 20 1951		REGISTERAR'S SIGNATURE J. Earl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE W. J. G.		ADDRESS Spring L. Metzger Millstadt Ill.	

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.....
Student Embalmer

Signed *John Freyer*

Licensed Embalmer No. *9635*

P. O. Address *East St. Louis Ill.*

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.