

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3499**
Registrar's No. **0675**

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 0675		
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 township) OR TOWN Saint Louis		c. LENGTH OF STAY (In this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		2199			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital			d. STREET ADDRESS (If rural, give location) 19 3703 Washington Blvd.					
3. NAME OF DECEASED (Type or Print) Marion C. Meyer			a. (First) _____ b. (Middle) _____		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) Jan. 20, 1953.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3		8. DATE OF BIRTH Nov. 18, 1895	9. AGE (In years last birthday) 57	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) Private secretary		10b. KIND OF BUSINESS OR INDUSTRY Physicians		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Marion H. Franklin			13b. MOTHER'S MAIDEN NAME Maria Porter		14. NAME OF HUSBAND OR WIFE Mansfield Meyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 493-10-4467		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hochester Franklin, 6314 Salome Ave				
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) Cerebral Embolism ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) Rheumatic Heart Disease rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus					INTERVAL BETWEEN ONSET AND DEATH 1 week 20 years 10 years	
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) _____		21f. HOW DID INJURY OCCUR? 416X		
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"/>		22. I hereby certify that I attended the deceased from Jan, 1949 , to Jan, 1953 , that I last saw the deceased alive on Jan 19, 1953 , and that death occurred at 6 A. m. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) Walter W. Davis, M.D.			23b. ADDRESS 539 N. Grand			23c. DATE SIGNED 1/20/53		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 21, 1953		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		
DATE REC'D BY LOCAL REG. JAN 21 1953		REGISTRAR'S SIGNATURE Craig Smith MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Craig, 4700 Washington Blvd.				

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

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed W. W. Wilburson

Licensed Embalmer No. 3575

P. O. Address St Louis 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.