

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016392  
STATE FILE NUMBER

FILED MAY 11 1959 Registration District No. 319 Primary Registration District No. Registrar's No. 27

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>STE. GENEVIEVE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE. GENEVIEVE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>STE. GENEVIEVE</u> <sup>0950</sup> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RR# 1</u>		Length of stay in lb <u>LIFE</u>	d. STREET ADDRESS (If outside, give location) <u>RR# 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY MAGDALENA MEYER</u>			4. DATE OF DEATH Month Day Year <u>MAY 2 1959</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 27 1887</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years) (If UNDER 1 YEAR, last birthday) Months Days Hours Min. <u>72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>OZORA MO</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>HENRY ROTH</u>	13b. MOTHER'S MAIDEN NAME <u>MARY FALKENT</u>
14. NAME OF HUSBAND OR WIFE <u>ANTON L MEYER</u>		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 <u>Carol Meyer Mo. Genevieve Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis + Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 15 min.</u> ?
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		331x	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>April 16, 1959</u> to <u>May 2, 1959</u> and last saw her alive on <u>May 2, 1959</u> Death occurred at <u>7:30 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Dr. Lawrence M. D.</u>	(Degree or title)	22b. ADDRESS <u>Ste. Genevieve Mo.</u>	22c. DATE SIGNED <u>5/2/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/4/59</u>	<u>SACRED HEART</u>	<u>OZORA MO</u>
24. FUNERAL DIRECTOR <u>Geo. C. Baskin</u>	ADDRESS <u>Ste. Genevieve Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>May 3, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Luella Baskin</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

color, country, etc. must use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be causally related.

MS  
DEC 27 1960

JAN 12 1960

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.

Student .....  
Signature of Student Embalmer

Signed *Adrian J. Elks* .....

Licensed Embalmer No. *4746* .....

P. O. Address *St. ...* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.