

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-049063
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3554

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1963

VS 300
Rev. 4/59

14000
28060

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY ST LOUIS COUNTY MO		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE CONN. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b 6wks	c. CITY OR TOWN INDIAN POINT LA COUNTY RIVERSIDE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MOTHER OF GOOD COUNCIL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS INDIAN POINT LA.
3. NAME OF DECEASED (Type or print) First ANNA Middle M Last MEIER		4. DATE OF DEATH Month 12 Day 6 Year 62	
5. SEX F	6. COLOR OR RACE W	7. Marital Status Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-21 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	9. AGE (last birthday) 83
11a. FATHER'S NAME Valentine KOSSLER		11b. MOTHER'S MAIDEN NAME Anna Marie UNKNOWN Deters	11. BIRTHPLACE (City and state or country) ST LOUIS MO
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> NO unknown) (If yes, give war or dates of service)		13. SOCIAL SECURITY NO. NONE	14. NAME OF HUSBAND OR WIFE JOHN H MEIER
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic cerebral vase disease		16. INTERVAL BETWEEN ONSET AND DEATH 5 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 6-4-62 to 12-6-62 and last saw her alive on 12-5-62 Death occurred at 3:15 ^{PM} on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Wayne O Gorla MD		22b. ADDRESS 100 No Euclid	
22c. DATE SIGNED 12-6-62			
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE	
REMOVED		12-7-62	
23c. NAME OF CEMETERY OR CREMATORY CALVARY		23d. LOCATION (City, town, or county) (State) ST LOUIS MO	
24. FUNERAL DIRECTOR KRIEGSHAUSER		25. DATE RECD. BY LOCAL REG. 12-6-62	
ADDRESS 9450 OLIVE ST RD		26. REGISTRAR'S SIGNATURE John B. Murphy MD	

USE BLACK INK OR TYPEWRITER RIBBON

DR. WAYNE GORLA
100 N. EUCLID
PO I-8687

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 William B White

Licensed Embalmer No. 4291

P. O. Address 4228 Kings Highway

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.