

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022690

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1559

FILED JUN 5 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Times Beach</u> | | Length of stay in 1b | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>328 Grove Ave</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3418 Pennsylvania</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>MIEGER</u> Last | | | 4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1963</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/22/1881</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 | 9. AGE (last birthday) <u>81</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. |
| 11. BIRTHPLACE (City and state or country) <u>New Hanover Ill.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>William Meyer</u> | | 13b. MOTHER'S MAIDEN NAME <u>not known</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Edward F</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Adele Doorack Times Beach Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>420.0</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 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"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>6:45</u> a.m. p.m. Month, Day, Year <u>5/13/63</u> | | | |
| 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>1949</u> to <u>5/13/63</u> and last saw her alive on <u>5/2/63</u> Death occurred at <u>6:45 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>George A. Dawson MD</u> (Degree or title) | | 22b. ADDRESS <u>6500 CHIPPEWA</u> | 22c. DATE SIGNED <u>5/13/63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>5/15/1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcius Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u> |
| 24. FUNERAL DIRECTOR <u>John L. Ziegenhein & Sons 7027 Gravois</u> ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>5-13-63</u> | 26. REGISTRAR'S SIGNATURE <u>John B. Mumphy M.D.</u> |

STATE OF MISSISSIPPI

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 *Donald Ben*

Licensed Embalmer No. 9963

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

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