

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026711

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 1820 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Overland</u>		c. CITY OR TOWN <u>Overland</u>	
Length of stay in 1b <u>38 yrs.</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>10451 Thorpe Ave.</u>		d. STREET ADDRESS (If outside, give location) <u>10451 Thorpe Ave.,</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JUDITH</u> Middle <u>L.</u> Last <u>MEYER</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5,</u> Year <u>1963</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>6-17-1895</u>
9. AGE (last birthday) <u>67</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Decker, Texas</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. NAME OF HUSBAND OR WIFE <u>Benjamin E. Meier</u>	
13a. FATHER'S NAME <u>Edward Zar</u>		13b. MOTHER'S MAIDEN NAME <u>Malvine Lindell</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> <u>None</u>		16. SOCIAL SECURITY NO. <u>Benjamin E. Meier-10451 Thorpe</u>	
17. INFORMANT <u>Benjamin E. Meier-10451 Thorpe</u>		Address <u>Overland 14</u>	
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>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
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)			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 _____ a.m. _____ p.m. Month, Day, Year _____	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>on 6/5/63</u> to _____ and last saw her alive on _____ Death occurred at _____ <u>5:50 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J.F. Snyder</u> (Degree or title) <u>J.F. SNYDER, MD</u>		22b. ADDRESS <u>9409 W. Milton, St. Louis 14, Mo.</u>	
22c. DATE SIGNED <u>6/6/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	23b. DATE <u>6-8-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Mausoleum</u>	23d. LOCATION (City, town, or county) (State) <u>Pagedale, Missouri</u>
24. FUNERAL HOME ADDRESS <u>Baumann Bros. Inc. 2504 Woodson Rd., Overland 14, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-7-63</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 David C. Gibson

Licensed Embalmer No. 3454
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.