

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-030285

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7751** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 1 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DE PAUL Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5015 DEVONSHIRE Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle Last MEURER		4. DATE OF DEATH Month JULY Day 27 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1 1873-90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY U-S-A	
13a. FATHER'S NAME HERMAN KNESE		13b. MOTHER'S MAIDEN NAME ELIZABETH SCHMIDT	14. NAME OF HUSBAND OR WIFE HENRY MEURER (DEC)
15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unknown) (If yes, give war or dates) NO		17. INFORMANT MARY OTTENLIPS 5015 DEVONSHIRE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 20 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cirrhosis of Liver			10 yrs
DUE TO (c) Emphysema			20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0			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 checked="" type="checkbox"/> NO <input 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.		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 7-20-63 to 7-27-63 and last saw her/him alive on 7-26-63 Death occurred at 10 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not write name) Harry A. Kutzis M.D.		22b. ADDRESS 5633 So Kingshighway	22c. DATE SIGNED 7/29/63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 30 1963	23c. NAME OF CEMETERY OR CREMATORY S.S. PETER & PAUL
24. FUNERAL DIRECTOR Thomas Kutzis 2906 Nevada		23d. LOCATION (City, town, or county) ST. LOUIS Mo.	25. DATE RECD. BY LOCAL REG. JUL 29 1963
26. REGISTRAR'S SIGNATURE Paul Smith M.D.			

Mr H Reed
5633 S. Kingshannon
P.O. 2456

1-3 True
1-3 Wed day

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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Glorius

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.