

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-035181**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **042**

Primary Registration District No. **1000**

Registrar's No. **1131**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

15110  
25110

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF **H.L. SENNE, M.D.** MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission): a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph,</b>		Length of stay in Tb. <b>57yrs</b>	c. CITY OR TOWN <b>St. Joseph,</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2017 Parkview</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2017 Parkview</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>H</b> Last <b>Meyer</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>18,</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3, 1906</b>
9. AGE (last birthday) <b>57</b>		IF UNDER 1 YEAR Months <b>57</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Armour &amp; Co</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>John Meyer</b>	
13b. MOTHER'S MAIDEN NAME <b>Christina Hagermeier</b>		14. NAME OF HUSBAND OR WIFE <b>Mabel Meyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>_____</b>	
17. INFORMANT <b>Mabel Meyer, St. Joseph, Mo</b>		Address <b>_____</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>
DUE TO (b) <b>Coronary Heart Disease</b>			3 yrs 5 mo.
DUE TO (c) <b>_____</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>_____</b>			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.) <b>_____</b>	
20c. TIME OF INJURY Hour <b>_____</b> Month, Day, Year <b>_____</b> a.m. <b>_____</b> p.m. <b>_____</b>			
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.) <b>_____</b>	20f. CITY, TOWN, OR LOCATION <b>_____</b>	COUNTY <b>_____</b> STATE <b>_____</b>
21. I attended the deceased from <b>4-26-60</b> to <b>9/18/63</b> and last saw him alive on <b>9-4-63</b> Death occurred at <b>3:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>H.L. Senne M.D.</b>		22b. ADDRESS <b>223 N. 7th St. Joseph, Mo</b>	22c. DATE SIGNED <b>9-20-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/20/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Joseph, Mo</b> (State) <b>Mo</b>
24. EMERAL DIRECTOR <b>_____</b> ADDRESS <b>St. Joseph, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>Sept. 23, 1963</b>	26. REGISTRAR'S SIGNATURE <b>Wm. Clark Goodell</b>

USE BLACK INK OR TYPEWRITER RIBBON

