

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038388

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2755

FILED SEP 23 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4030
2 4030
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4 1
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9 94221
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

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>Moline</u> Length of stay in 1b		c. CITY OR TOWN <u>Moline</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Halls Ferry Memorial Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>2115 Kappa</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>Halls Ferry Memorial Home</u>	
3. NAME OF DECEASED First Middle Last <u>Eliza Meyers</u>			4. DATE OF DEATH Month Day Year <u>September 4 1963</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/5/1880</u>
9. AGE (last birthday) <u>83</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>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>William Meyers</u>	
13b. MOTHER'S MAIDEN NAME <u>Ellen Elson</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William Roberts</u>		Address <u>South Side National Bank</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>Cerebral thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular. unknown</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral malaria</u>			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 Month, Day, Year 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 <u>Oct 12, 1960</u> to <u>Sept 4, 1963</u> and last saw her ^{born} alive on <u>Sept 3, 1963</u> Death occurred at <u>10:35 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Lewis Lillmann MD</u>		22b. ADDRESS <u>8231 Clayton Rd (17)</u>	22c. DATE SIGNED <u>9/4/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>9/6/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Picker Cemetery</u>
23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		23e. (Stamp)	
24. FUNERAL DIRECTOR <u>John L Ziegenhein & Sons</u>		ADDRESS <u>7027 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>9-4-63</u>
26. REGISTRAR'S SIGNATURE <u>John B. 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 Donald Bing

Licensed Embalmer No. 4863

P. O. Address H Garrison

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.