DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36703

Registration District No. 5-7-1724 1939 Primary Registration District No. 4335 Registrar's No. 52

1. PLACE OF DEATH:

(a) County Montgan

(b) City or town California Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Latham Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Montgan

(c) City or town California
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Charles Christopher Meyer

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Male

5. Color or race W

6. (a) ~~Single, widowed~~, married, divorced ____

6. (b) Name of husband or wife Lodaun

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Feb. (Month) 8 (Day) 1866 (Year)

8. AGE: Years 73 Months 8 Days 1 If less than one day ____ hr. ____ min.

9. Birthplace California-Mo (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Help at Relay Office

11. Industry or business ____

MOTHER FATHER

12. Name William Meyer

13. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name Katherine Kroer

15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs C. C. Meyer

(b) Address California Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/39 (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill Cem

18. (a) Signature of funeral director Williams & Friedmeyer

(b) Address California Mo

19. (a) 10-10-39 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9 Oct.
year 1939 hour 9 a.m. minute 30 A. M.

21. I hereby certify that I attended the deceased from Oct 7, 39, 1939 to Oct 9, 1939 that I last saw h. alive on Oct 9, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uraemia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations ____

Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature J. P. Burke Jr (M. D. or other)

Address California, Mo Date signed 10/12/39

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 1 x19511

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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_____, Registered Apprentice No._____, working under my personal supervision.

Signed Hugh E Williams

Licensed Embalmer No. 3537

P. O. Address California 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36703
Do not use this space.

1. PLACE OF DEATH
(a) County Moniteau Registration District No. 571
(b) Township Primary Registration District No. 4335 Registered No. 62
(c) City California (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles Christopher Meyer

(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	73	8	1	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE ,19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED , 19 Local Registrar.

SUPPLEMENTARY

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 9 ,1939

22. I HEREBY CERTIFY, That I attended deceased from ,19 to ,19
I last saw h alive on ,19 Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Uremia	
Renal Compression due to	
Prostatic Stricture of urethra	

Other contributory causes of importance:

1 3 6 P

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ,19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) J. P. Burk Jr. , M. D.
(Address) California Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.