

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

PLACE OF DEATH

County _____

Township _____

or Village _____

or City _____

Registration District No. _____

Primary Registration District No. _____

(NO. *2830* to *Beau* St.: *9* Ward)

File No. *24390* ~~2449~~

Registered No. *5988*

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME *Louis Spellmeyer*

PERSONAL AND STATISTICAL PARTICULARS

SEX <i>Male</i>	COLOR OR RACE <i>White</i>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>Single</i>
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DATE OF BIRTH *June 21, 1911*
(Month) (Day) (Year)

AGE *1* yrs. *6* mos. *16* ds.
If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work *at home*
(b) General nature of industry, business, or establishment in which employed (or employer) *0*

BIRTHPLACE
(City or town, State or foreign country) *St. Louis*

NAME OF FATHER *Louis E. Spellmeyer*

BIRTHPLACE OF FATHER
(City or town, State or foreign country) *St. Louis*

MAIDEN NAME OF MOTHER *Minnie Robinson*

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) *Ills.*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Louis Spellmeyer*

(ADDRESS) *2830 So. Beau*

Filed *July 8* 1912 *Max B. Stackloff*

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *July 7, 1912*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *July 5*, 1912, to *July 7*, 1912, that I last saw him alive on *July 7*, 1912, and that death occurred, on the date stated above, at *3 P.m.*

The CAUSE OF DEATH* was as follows:
Gastro Enteritis, Complicated with
Bronchial Pneumonia. *119 B*
107 A
104
(Duration) yrs. mos. *14* ds.

Contributory *Dentition*
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) *C. H. Diehl* M. D.
July 7, 1912 (Address) *2353 South Broadway*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence.

PLACE OF BURIAL OR REMOVAL *Bethania* DATE OF BURIAL *July 8, 1912*

UNDERTAKER *Walter Helder* ADDRESS *2331 So. Beau*

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.

