

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

1 PLACE OF DEATH

County .....

Township .....

or

Village .....

or

City .....

Registration District No. **791**

File No. **22599**

Primary Registration District No. **1003**

Registered No. **5442**

(NO **14445** **Kassuth** St. **71** Ward)

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

2 FULL NAME **Mary D. Meyer**

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 SINGLE MARRIED WIDOWED OF DIVORCED **Married**  
(Write the word)

6 DATE OF BIRTH **Jan 9th 1870**  
(Month) (Day) (Year)

7 AGE **40 yrs 4 mos 30 ds.** If LESS than 1 day, .... hrs. or .... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) **Ill.**

PARENTS  
10 NAME OF FATHER **Joseph Rudolph**  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) **Germany**  
12 MAIDEN NAME OF MOTHER **Amie Schaefer**  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) **Germany**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) **H. E. Meyer**  
(Address) **Wardens 7th**

15 Filed **Jan 2 1916** 1916 **Mar 6** **Starkloff** Registrar

1 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **June 2 1916**  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from **Jan 10 1915** to **June 2 1916**, that I last saw him alive on **June 1st 1916**, and that death occurred, on the date stated above, at **12:30 am**

The CAUSE OF DEATH\* was as follows:  
**Carcinoma of Stomach**  
**10** (Duration) **1** yrs. **6** mos. **-** ds.

CONTRIBUTORY (Secondary) **Frank Hiechman, D.**  
(Duration) .... yrs. .... mos. .... ds.  
(Signed) **June 2 1916** (Address) **Humboldt St**

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL **Humboldt** DATE OF BURIAL **6/2 1916**

20 UNDERTAKER **M. H. ...** ADDRESS **2835 Blue**

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.

