DO NOT TEAR DEAR OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS 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.

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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis (NO. City Hospital St. 16 Ward)

Registration District No. 791 File No. 30860

Primary Registration District No. 1003 Registered No. 8790

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

2 FULL NAME 7147 Louis Geiger

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: Feb 20 1862 (Month) (Day) (Year)

7 AGE: 56 yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): day

9 BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

10 NAME OF FATHER: Edmund Geiger

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Missouri

12 MAIDEN NAME OF MOTHER: Nor Brown

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E Rowan
(Address) City Hospital

15 Filed SEP 20 1918, 191..., Max C Starkloff, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 17, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 10, 1918, to Sept 17, 1918, that I last saw him alive on Sept 17, 1918, and that death occurred, on the date stated above, at 8 ~ P.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Disease
mitral regurgitation
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) 0 (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M.D.
Sept 18, 1918 (Address) City Hospital

*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. 7 ds. In the State 70 yrs. ....mos. ....ds.
Where was disease contracted if not at place of death?
Former or usual residence 7875 Adams

19 PLACE OF BURIAL OR REMOVAL: Father Dickson DATE OF BURIAL: 9/21, 1918

20 UNDERTAKER: L. S. Williams ADDRESS: 3232 Pine

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

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

2 FULL NAME .....

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....

that I last saw h.....alive on....., 191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

*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

DATE OF BURIAL

....., 191.....

20 UNDERTAKER

ADDRESS