

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

10359

1. PLACE OF DEATH

County Buchanan Registration District No. 85 File No. _____
Township _____ Primary Registration District No. 1001 Registered No. 491
City St. Joseph (No. 302, So. 13th St.) St. _____ Ward _____

2. FULL NAME

Lina Meyer

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S., if of foreign birth? 60 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov, 17, 1846

7. AGE YEARS 77 MONTHS 5 DAYS 5 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Household
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER Z. DeMuth
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Esther Hirschel
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany

14. INFORMANT Mrs. Louis Vossen (Address) 2102 Faraon St.

15. FILED 24 1924 Eva Harrison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr, 22, 1924 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 January, 1923, to 22 April, 1924 that I last saw her alive on 21 April, 1924, and that death occurred, on the date stated above, at 5:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paroxysms of Angina
4/20

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

8 DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY: _____

WHAT TEST CONFIRMED DIAGNOSIS: _____

(Signed) Frank E. Green, M. D.

Apr. 22, 1924 (Address) 700 Franklin

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Adath Joseph Cemetery DATE OF BURIAL Apr, 24, 19 24

20. UNDERTAKER H. Meichoffe ADDRESS 1302 Faraon S

K. 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.

