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

Do not use this space.

2560

1. PLACE OF DEATH

County ..... Registration District No. 7 ..... File No. .....

Township ..... Primary Registration District No. 1003 ..... Registered No. 96

City St. Louis Mo. (No. Lutheran Hosp't. ..... St. ..... Ward)

2. FULL NAME Elizabeth Meyer

(a) Residence. No. 3234 Osceola St., 15 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1 - 1867.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	0	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

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

(c) Name of employer

126
127B
98P

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) St. Louis Mo.

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) "

14. INFORMANT Alvin Meyer (Address) 3234 Osceola

15. FILED JAN - 4 1927 19 Max C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 1 - 1927.

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5th 1926 to Jan. 1st 1927, that I last saw her alive on Jan. 1st 1927, and that death occurred, on the date stated above, at 10:40a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis

123 (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Acute Cholecystitis & Cholecystolithiasis (duration) ..... yrs. 1 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 3234 Osceola St.

DID AN OPERATION PRECEDE DEATH? yes DATE OF 12/13/26.

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? physical, clinical & laboratory findings

(Signed) W. H. Walters, M.D.

1/2, 1927 (Address) 3608 S. Grand Bl.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New St. Marcus	Jan. 3 1927.

20. UNDERTAKER	ADDRESS
Ziegenhein Bros.	2623 Cherokee St.

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.