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

Do not use this space.

25553

**1. PLACE OF DEATH**

County..... Registration District No. 791 File No.....

Township..... Primary Registration District No. 1003 Registered No. 7146

City St. Louis (No. Baptist Hospital ..... St. ..... Ward)

**2. FULL NAME** Carrie Meyer Franklin & Garrison

(a) Residence. No. 4252 S. Nat Bridge St., 10 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 John Meyer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 28, 1880

| 7. AGE YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|
| 47 | 2 | 8 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(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) Penn

PARENTS

10. NAME OF FATHER Wm Quintenbunting

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

12. MAIDEN NAME OF MOTHER Anna Hiles

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

14. INFORMANT John Meyer
(Address) 4252 S. Nat Bridge

15. FILED AUG -8 1927, 19..... Max C. Starcke
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 6, 1927

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1927, to Aug 6, 1927, that I last saw h. lv. alive on Aug 5, 1927, and that death occurred, on the date stated above, at 3 40 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilatation Heart
6 6 B
T B
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY) Toxic Exophthalmic Goiter (duration) yrs. 1 mos. 14 ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

8/6 (Signed) O. Carnes, M. D
, 1927 (Address) 320 Metro Bldg

*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 |
|---|---|
| Memorial Park | Aug 8, 1927 |
| **20. UNDERTAKER** | **ADDRESS** |
| A. Diehlmann Usual | 1905 Union |

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

Met. Bldg
$1^{30}$ to 4 P.M.