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

Do not use this space.

28404

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 7926

Township ..... Primary Registration District No. ..... Registered No. .....

City St Louis (No. City Infirmary St. ..... Ward)

2. FULL NAME David Mateer

(a) Residence. No. City Infirmary St., 13 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 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)
Male	White	Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Abt 1851

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
about	76	?	?	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer ?

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

PARENTS

10. NAME OF FATHER James Mateer

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

12. MAIDEN NAME OF MOTHER ? Mk

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

14. INFORMANT Mrs Effinger (Address) City Infirmary

15. FILED SEP -6 1927, 19 Mark C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 5 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1927, to Sept 4, 1927 that I last saw him alive on Sept 4, 1927, and that death occurred, on the date stated above, at 1:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy. Cerebral Hemorrhage

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (SECONDARY) Bronchial pneumonia

(duration) yrs. mos. 3 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? Clinical

(Signed) R C Lanning, M. D

, 19 (Address) City Infirmary

*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 New St. Marcus Cem. DATE OF BURIAL 9-7 1927

20. UNDERTAKER Peetz Bros. 3029 Lafayette ADDRESS

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.