

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

Do not use this space.

29140

1. PLACE OF DEATH

County.....
Township.....
City..... *St Louis*

Registration District No. **791**
Family Registration District No. **1003**
(No. *Christian Hos.*)

File No.....
Registered No. **8730**
St. Ward)

2. FULL NAME

Adolph E. Meier
(a) Residence, No. *4508th Athlone Bldg* 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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Martha Meier*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 14-1860*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 1 15

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Clerk*
(b) General nature of industry, business, or establishment in which employed (or employer) *Office*
(c) Name of employer

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

10. NAME OF FATHER *Ernest J. Meier*

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

12. MAIDEN NAME OF MOTHER *Heligabell Hannah*

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

14. INFORMANT *Mrs. Martha Meier*
(Address) *4508th Athlone Bldg*

15. *OCT -1 1927*
FILED *Marie Starostoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 29- 1927*
17.

I HEREBY CERTIFY, That I attended deceased from *Sept 28*, 1927, to *Sept 29*, 1927, that I last saw him alive on *Sept 28*, 1927, and that death occurred, on the date stated above, at *2 a.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
465 Carcinoma Stomach -
91
716
440
(duration) yrs. mos. ds. *1 mos.*
CONTRIBUTORY (SECONDARY) *Arteriosclerosis*
Sec Anemia (duration) yrs. mos. ds. *1 yrs.*

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

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

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *Geo Emmelias*, M. D.

(Address) *2917 St Louis Ave*

*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 *Young Cemetery* DATE OF BURIAL *Oct 2- 1927*

20. UNDERTAKER *By Gidner and Co* ADDRESS *7217 N Market St*

AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

