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

Do not use this space. 3263

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 889

City St Louis Mo (No. St Johns Hosp St. ..... Ward)

2. FULL NAME Myrtle C. Weingart

(a) Residence. No. 4815 Carter Ave 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 Anthony Weingart

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 14 - 1898

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	29	9	10	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Joseph Meloy

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

12. MAIDEN NAME OF MOTHER Elizabeth Blunk

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

14. INFORMANT Anthony Weingart
(Address) 4815 Carter Ave.

15. FILED JAN 24 1928 Max C Starkloff
REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 1928

17. I HEREBY CERTIFY, That I attended deceased from 12/20/27 ....., 19....., to 1/24, 1928 that I last saw h 27 alive on 1/24, 1928, and that death occurred, on the date stated above, at 4 - AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Cardiac Failure
Tuberculous Meningitis
26
24H (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Tuberculosis of Spine 10th - 11th dorsal (duration) 1 yrs. 6 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS WHERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Xray.

(Signed) Geo. T. Nelson M. D
1/24, 1928 (Address) 1006 So Jefferson

*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 Albany Ind	Jan 25 1928
20. UNDERTAKER	ADDRESS 1417
Hy Leidner Und Co	N. Market St

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.