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.

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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 22546

Township ..... Primary Registration District No. [illegible] Registered No. 6754

City St. Louis, Mo. (No. City Hospital St. ..... Ward)

2. FULL NAME Joseph Frank Meyer

(a) Residence. No. 1900 Cherokee Street St., 24 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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 Mattie Meyer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 1st, 1884

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
44	4	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cafe Proprietor

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER John Meyer

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mattie Meyer
(Address) 1900 Cherokee

15. FILED 28, 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25th, 19 28

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 8:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage of Brain
Fracture skull
Struck with hammer
175B (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 97A Homicide
..... (duration) ..... yrs. ..... mos. ..... ds.

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

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Wm Dever M.D.

6/27, 19 28 (Address) Coroners Office

*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: S. S. Peter & Paul
DATE OF BURIAL: June 28- 19 28.

20. UNDERTAKER: Wacker-Kilderle
ADDRESS: 2331 S. Broadway