Dr Meador 2303 Salisbury

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

Township..... Primary Registration District No. 1003

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

File No. 25563

Registered No. 7379

2. FULL NAME Amelia Kohlmeyer

(a) Residence. No. 3403 So 2nd St St., 24 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 Louis Kohlmeyer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 6 1874

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	54	6	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 27B

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

(c) Name of employer Self

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

PARENTS

10. NAME OF FATHER Adam Smith

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

12. MAIDEN NAME OF MOTHER Elizabeth Miller

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

14. INFORMANT Louis Kohlmeyer
(Address) 3403 So 2nd St St Louis Mo.

15. FILED JUL 16 1928 Mary C Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-15 19 28

17. I HEREBY CERTIFY, That I attended deceased from July ..... 19 28 to July ..... 19 28 that I last saw her alive on July 14 19 28, and that death occurred, on the date stated above, at 440 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis
Heart Fail
Leg (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Diab
(duration) ..... yrs. ..... mos. ..... 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? Physical

(Signed) H. L. Meador, M. D.

7-16 19 28 (Address) 2303 Salisbury

*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 Old St Marcus Cemetery

DATE OF BURIAL 7-17 19 28

20. UNDERTAKER Weick Bros 2201

ADDRESS So Grand Blv

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.