

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

Do not use this space.

32563

1928

1. PLACE OF DEATH

County.....*Warren*
Township.....*Charlotte*
City.....*(No)*

Registration District No.....*1884*
Primary Registration District No.....*107*

File No.....
Registered No.....*13*
St.....*St.* Ward.....

2. FULL NAME

Caroline Meyer

(a) Residence. No.....*St.* 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (or) WIFE OF *Frank Meyer*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 20 - 1866*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
61 11 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *At Home*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Warren Co Missouri*
(STATE OR COUNTRY)

10. NAME OF FATHER *Henry Petersmeyer*

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

12. MAIDEN NAME OF MOTHER *Sophie Schafke*

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

14. INFORMANT *William Meyer*
(Address) *Waverly, Mo*

15. FILED *Oct 25 1928* *J C Johnson*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 29th 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 24th* 1928, to *Sept 29th* 1928, and that I last saw h. *er* alive on *Sept 29*, 1928, and that death occurred, on the date stated above, at *8* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Collection of mucus
in the neck
and back*
(duration) yrs. mos. *4* ds.

CONTRIBUTORY (SECONDARY) *Hypostatic pneumonia*
(duration) yrs. mos. *2* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *Sept. 24 & 29*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *clinical*
(Signed) *Herbert H Schmidt*, M. D.
, 19 (Address) *Marthastalk, Mo*

*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 *Lepstadt Church* DATE OF BURIAL *10/1st 1928*

20. UNDERTAKER *F O Hubing* ADDRESS *Warren Co Mo*

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.

Blank area for medical notes or examination findings.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Warren Registration District No. 884 File No.
Township Charrette Primary Registration District No. 6176 Registered No.
City (No.) St. Ward)

2. FULL NAME Caroline Meyer
(a) Residence, No. St. 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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 20-1866

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED Oct 28 GC Johnson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 19 28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebritis Erysipelas neck and back Carbuncle
LABORATORY Stobas pneumoniae
(SECONDARY) typhostatic pneumoniae

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? yes DATE OF Sept 24-28

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Herbert D Schumaker
, 19 (Address) Northasville, Mo

*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

19

20. UNDERTAKER

ADDRESS

E. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY IN PLAIN TERMS, so that it may be properly classified. Fact statement of OCCUPATION is required. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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