

NOV 21 1928

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

Do not use this space.

35195

1. PLACE OF DEATH

County St. Louis
Township Union
City St. Louis (No. _____) St. _____ Ward _____

Registration District No. 282
Primary Registration District No. 5401

File No. _____
Registered No. 57
St. _____ Ward _____

2. FULL NAME

Sola Ann Meyers

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Jacob Meyers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 18-1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
38 5 18

8. OCCUPATION OF DECEASED

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

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

PARENTS
10. NAME OF FATHER Ruben Chamberlain
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary G Phelps
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ark.
(STATE OR COUNTRY)

14. INFORMANT Jacob Meyers
(Address) Osborne Hall

15. FILED 10/6 28 Ed. Anderson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 5 1928

17. I HEREBY CERTIFY That I attended deceased from Oct 2 1928 to Oct 5 1928 that I last saw h. or alive on Oct 5 1928, and that death occurred, on the date stated above, at 7:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Puerperal Septicemia

14.5 hr. (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 14 hr. (duration) yrs. mos. da.

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?
(Signed) Wm R Brown M. D.

Oct 6 1928 (Address) _____

*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 Elder Ave. DATE OF BURIAL 10/7 1928

20. UNDERTAKER Ed Anderson ADDRESS Osborne Hall

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.

PERMANENT RECORD

