

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

Do not use this space.

43302

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis, Mo.*

Registration District No. *701*
Primary Registration District No. *1003*
City *Ohio*

File No.
Registered No. *12610*
St. (Ward)

2. FULL NAME

John H. Geers

(a) Residence. No. St., *274* Ward.

(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

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

April 18th 1834

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>94</i>	<i>8</i>	<i>5</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Retired*

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Germany*

14.

INFORMANT *Melba Femmen*
(Address) *2639 Accorac St.*

15.

FILED *25* 19*27* *M. C. Ford*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Dec 23rd 1928

17.

I HEREBY CERTIFY That I attended deceased from *Jan 1*, 19*26* to *Dec 23*, 19*28*
that I last saw h. *alive* on *Dec 22*, 19*28*, and that death occurred, on the date stated above, at *2:30 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis

CONTRIBUTORY (SECONDARY)

Arterio-sclerosis

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 Did an operation precede death? *no* DATE OF *no*

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? *clinical course*

(Signed) *W. Schneider*, M. D.

, 19 (Address) *2708 Lynch St. Louis 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

St. Peter & Paul C.

DATE OF BURIAL

Dec 27 1928

20. UNDERTAKER

J. H. Gebken Lull Co.

ADDRESS

2628 Gravois

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

R. 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.

