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

Do not use this space.

8877

1. PLACE OF DEATH

County..... Registration District No. 791 1003 File No.....

Township..... Primary Registration District No. ..... Registered No. 2569

City..... (No. Christian Hospital St. ..... Ward)

2. FULL NAME Dorothy B. Merz

(a) Residence. No. 4412a Red Bud St., 10 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	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-17-1909

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	20	0	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Office Work

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Joseph Merz

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

12. MAIDEN NAME OF MOTHER Mary Klockenkemper

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

14. INFORMANT Joseph Merz
(Address) 4412a Red Bud Ave

15. FILED 26 ..., 19 ... Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-24 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1929, to Feb. 24, 1929 that I last saw her alive on Feb. 24, 1929, and that death occurred, on the date stated above, at 2 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Exophthalmic Goiter

66B

600

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

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

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) S. A. Van Hoefen, M. D

2/25, 1929 (Address) 8313 Halls Ferry Rd

*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
Calvary Cemetery	2-27 1929
20. UNDERTAKER	**ADDRESS**
W. A. Stock Und Co.	2176 Grand

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.

8313 Halls Ferry