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

Do not use this space.

35317

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 10060

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

City St Louis (No. 6215 Marmaduke ave St. ..... Ward)

2. FULL NAME Sarah Myers

(a) Residence. No. 6215 Marmaduke ave St., 3 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 Samuel S. Myers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 3rd 1860

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
68	11	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS

10. NAME OF FATHER John Shepard

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

12. MAIDEN NAME OF MOTHER Mary Shepard

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

14. INFORMANT Clarence Myers
(Address) 7029 Maid ave

15. FILED OCT 11 1929 Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 12 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 12, 1929, that I last saw her alive on Oct 11th, 1929, and that death occurred, on the date stated above, at 1 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemmorrhage
(Apoplexy
(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis
(duration) 5 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) H A Steinmann, M. D
10/12, 1929 (Address) 5715 Southwest Ave

*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 Concordia Cemetery — DATE OF BURIAL Oct 14, 1929

20. UNDERTAKER Kingshaw Und Co — ADDRESS 4228 S Kingshighway

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.

Dr Steimann
5715 Southwest Ins 1-3