

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

Do not use this space.

20861
20861
File No. _____
Registered No. 5663
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. 701
Township _____ Primary Registration District No. 1003
City St. Louis (No. City Infermary)

2. FULL NAME

Cecelia Mayer

(a) Residence. No. 601 East Jesson Ave., 13 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) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) About 78 Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
about 78 Unknown

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Robert Cook

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

12. MAIDEN NAME OF MOTHER Mary Cook

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

14. INFORMANT Mrs. G. J. Kennedy
(Address) 4234 Delcor

15. FILED JUN 11 1930 W. C. Parker
19 _____ REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-8 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-25, 1929, to 6-8, 1930, that I last saw her alive on 6-8, 1930, and that death occurred, on the date stated above, at 6 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93 cor. myocarditis
97 A
Broncho-pneumonia (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) pneumonia
(duration) _____ yrs. _____ mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. C. Parker, M. D.

6-10, 1930 (Address) 5600 Arsenal

*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. Olive DATE OF BURIAL 6/11 1930

20. UNDERTAKER Southern U & PB ADDRESS 6320 So. 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.

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RECORD

