

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

Do not use this space.

21058  
~~21157~~

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No. ....

Registered No. **5895**

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **2518 Palm** St. **20** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **36** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

*male*

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

*Hettie Meyer*

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

*May 31 1874*

7. AGE

YEARS *56*

MONTHS *0*

DAYS *16*

If LESS than 1 day, .....hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

*woodwork*

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

(c) Name of employer

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

*St. Louis*

10. NAME OF FATHER

*Henry Meyer*

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))

*St. Louis, Missouri*

14. INFORMANT

(Address)

*City Hospital*

15. FILED

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REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

*June 16 30*

17. I HEREBY CERTIFY, That I attended deceased from

*June 3 1930* to *June 16 1930* that I last saw him alive on *June 16 1930*, and that death occurred, on the date stated above, at *6:30 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Pulmonary tuberculosis*  
*23A*

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

CONTRIBUTORY (SECONDARY)

*31*

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, *No*

19. DID AN OPERATION PRECEDE DEATH? *No*

DATE OF

20. WAS THERE AN AUTOPSY?

*Clinical X-ray*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Carl H. Hoyer M.D.*  
*17 30* (Address) *City Hospital*

\*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

*St. John's* *June 19 1930*

20. UNDERTAKER

ADDRESS

*Wm. F. Paschedag* *2825 No. 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.

RECORD IS A PERMANENT RECORD

Meeps.

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