

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

Do not use this space.

28632

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1007
 City St. Louis, Mo. (No. City Hospital #2) St. _____ Ward _____

File No. _____
 Registered No. 8540

2. FULL NAME

Annie Meyers
 (a) Residence. No. 2605 Gambol St. 21 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
<u>abk 64</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (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) Tenn.

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT A. Garwood Coates
 (Address) City Hospital #2

15. FILED ALG 22 1930
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8 - 11 - 1930

17. I HEREBY CERTIFY, That I attended deceased from 8 - 6 - 1930, to 8 - 11 - 1930, that I last saw h. e. alive on 8 - 11 - 1930, and that death occurred, on the date stated above, at 11:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Regurgitation
13 1/2
9 1/2 H (duration) yrs. mos. ds.
 CONTRIBUTORY Ch. nephritis
 (SECONDARY) (duration) 1 yrs. 4 mos. ds.

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

DID AN OPERATION PRECEDE DEATH? N DATE OF _____
 WAS THERE AN AUTOPSY? N

WHAT TEST CONFIRMED DIAGNOSIS Clinical - Lab -
 (Signed) Henry C. Sampson M. D.
8-12-1930 (Address) City Hosp. #2

*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 Unknown
 DATE OF BURIAL 8-31-1930
Father Dickerson

20. UNDERTAKER Tom Nunley - 4125 Finney Ave.
 ADDRESS _____

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.

