WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

41005

1. PLACE OF DEATH

County ..... Registration District No. 791 ~~1002~~

Township ..... Primary Registration District No. .....

City St. Louis (No. City Hospital #1 St. ..... Ward)

File No. .....

Registered No. 11666

2. FULL NAME Monroe Meis

(a) Residence. No. 4208 W Easton St., 11 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)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 31-1888

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	41	11	12	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Owensboro
(STATE OR COUNTRY) Ky

PARENTS

10. NAME OF FATHER Frank Meis

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

12. MAIDEN NAME OF MOTHER Bertha Heneman

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

14. INFORMANT Nora Meis
(Address) 4208 W Easton Av

15. FILED DEC 13 1930 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 12 1930

17. I HEREBY CERTIFY, That I attended deceased from No Physician in attendance, 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 9:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gunshot Wound of Head (self-inflicted) at residence

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

CONTRIBUTORY (SECONDARY) Suicide

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

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

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Keener, M.D.

12/13/30 (Address) Dep Coroner

*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
National Cemetery	12/15 1930
20. UNDERTAKER	ADDRESS
C. Hoffmeister Und & L Co	7814 S. Broadway