

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

1003

Township.....

Primary Registration District No.

City **St. Louis** (No. **21989**)

City **City Hosp.**

File No.

15686

Registered No. **4126**

St. Ward)

2. FULL NAME

Herman C Mayer

(a) Residence. No. **1216 Lynch St.** **23** 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 **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 10 - 1873**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	57	8	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. **Laborer 5⁵⁸**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer **Bucks. Store**

9. BIRTHPLACE (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

10. NAME OF FATHER **Frederick Mayer**

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

12. MAIDEN NAME OF MOTHER **Christiana Lippoth**

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

14. Hospital Informant **Grace Kopp**
(Address) **City Hospital**

15. **FILED** **1931** **St. Louis**
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 2nd 1931**

17. I HEREBY CERTIFY, That I attended deceased from **March 18th 1931**, to **April 2nd 1931**, that I last saw him alive on **April 2nd 1931**, and that death occurred, on the date stated above, at **3:45 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93C Chronic alcoholism
114 Chronic myocarditis
75B (duration) yrs. mos. ds.
CONTRIBUTORY **lung abscess etiology**
(SECONDARY) **unknown** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical + autopsy**
(Signed) **V. Scherman** M. D.

4/2 1931 (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 **New St Marcus** DATE OF BURIAL **Apr 4 1931**

20. UNDERTAKER **Wacker Helderle** ADDRESS **2331 S Bldg**

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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