

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

Do not use this space.

1. PLACE OF DEATH

County Wright

Registration District No. 19

File No. 24122

Township Wright

Primary Registration District No. 4538

Registered No. _____

City Rock Port

(No. _____)

St. _____

Ward _____

2. FULL NAME

Emma Dick MeyerKath

(a) Residence, No. _____ St. _____

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)

Married

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

John MeyerKath

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

1-14-1872

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, _____ hrs. or _____ min.

59

6

17

8. OCCUPATION OF DECEASED

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

Housewife

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Dick Miller

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Grace Zimmermann

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

Mrs Ed Sanders
Rock Port, Mo.

15.

FILED

7-31-1931

Mary J. Chamberlain
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

7-31

1931

17.

I HEREBY CERTIFY, That I attended deceased from

7/31/31

7/30/31

19____, 19____, and that I last saw him ER alive on 7/31/31, 19____, and that death occurred, on the date stated above, at 7 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CEREBRAL HEMORRHAGE

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? NONE

(Signed) A. C. Chamberlain, M. D.

(Address) Rock Port, Mo.

*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

Under Cemetery

8-2

1931

UNDERTAKER

Edy Bartholomeu

ADDRESS

Rock Port, Mo.

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.

AUG 24 1931

