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.

2966

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 2966

Township ..... Primary Registration District No. ..... Registered No. 690

City St Louis Mo (No. 1919 N. 15th St ..... St. ..... Ward)

2. FULL NAME Cecilia Tiemeyer

(a) Residence, No. 1919 N. 15th St. St., 26 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 24 - 1864

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
67	10	26	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 235

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ills

FATHER

13. NAME Dont know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont know 31

MOTHER

15. MAIDEN NAME Dont know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont know

17. INFORMANT (ADDRESS) Mrs Cecilia Wack 1919 N. 15th St

18. BURIAL, CREMATION, OR REMOVAL

PLACE Calvary DATE Jan 23 1932

19. UNDERTAKER (ADDRESS) Hy Leidner Und Co 1417 N. Market St

20. FILED Jan 21 1932 19 [signature] Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 20 1932

22. HEREBY CERTIFY, That I attended deceased from Jan 2, 1932, to Jan 20, 1932

I last saw her alive on Jan 20th, 1932 Death is said to have occurred on the date stated above, at 12 P m.

The principal cause of death and related causes of importance were as follows:

Chr. Myocarditis Decompensated

Date of onset

Other contributory causes of importance: Cardiac Asthma

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Matt J Crowe, M. D.

(Address) 5738 N. Florissant