

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

Do not use this space.

3394

**1. PLACE OF DEATH**

County ..... Registration District No. *571*  
Township ..... Primary Registration District No. *100*  
City *St. Louis* No. *City Hospital*

File No. ....  
Registered No. *293*  
St. .... Ward)

# *17200*

**2. FULL NAME**

(a) Residence, No. *3111 - Blair St 26* Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

6a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Emil Meyer*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Mar. 25 1896*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*36 9 13*

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. *at home*

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) *Garfield Illinois*

13. NAME *Rollie Turner*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *Hospital Informant Grace Kopp City Hospital*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Matthews* DATE *Jan 9 1933*

19. UNDERTAKER (ADDRESS) *Ambrosius Bond Co 4234 Manchester Ave*

20. FILED *JAN - 9 1933* Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan. 7 1933*

I HEREBY CERTIFY (that I attended deceased from *Jan. 6th 1933* to *Jan 7th 1933*)

I last saw him/her alive on *Jan 7th 1933* Death is said to have occurred on the date stated above, at *12:15 a.m.*

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

*Broncho-Pneumonia  
95%  
109%*

Other contributory causes of importance:  
*Arterio-Sclerotic Heart Disease  
Auricular Fibrillation*

Name of operation ..... Date of .....  
What test confirmed diagnosis? *Phys. & Path.* Was there an autopsy? *Yes*

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? .....  
If so, specify .....  
(Signed) *J. M. Mendenhall*, M. D.  
(Address) *City Hospital*

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.

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