

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.

1934 JUN 23 1934

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

Do not use this space.

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Mason Primary Registration District No. 3079
City Hannibal (No. 1500, Market) St. _____ Ward _____

File No. 13552
Registered No. 118
St. _____ Ward _____

2. FULL NAME

Chas. A. Meyers

(a) Residence, No. 1500 Market 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 19th 1857</u>				
7. AGE YEARS <u>76</u>	MONTHS <u>10</u>	DAYS <u>16</u>	If LESS than 1 day, _____ hrs. or _____ min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as planer, sawyer, bookkeeper, etc. <u>Retired</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	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) Loganport Indiana

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT Dr. F. H. Brown (ADDRESS) 202 F Building, Hannibal Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Albert Am DATE 4/8/34 19.

19. UNDERTAKER James O'Donnell (ADDRESS) Hannibal Mo

20. FILED Apr 13 1934 R. H. Scholer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 5th 1934

I HEREBY CERTIFY that I attended deceased from Mar 27 1934 to Apr 5 1934. I last saw him alive on Apr 5 1934. Death is said to have occurred on the date stated above, at 11:15 a.m.

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

Chronic myocardial degeneration. Date of onset 27yr.

Other contributory causes of importance: 93C

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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. H. Scholer M. D.
(Address) Hannibal Mo

