

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

Do not use this space.

1. PLACE OF DEATH

County St. Louis

Registration District No. 1160

File No. 19099

Township University City

Primary Registration District No. 4470

Registered No. 56

City University City (No. 6600 Washington Ave.)

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 6600 Washington Ave.

Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 3 mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 16th 1934

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF widow of August Bayer

22. I HEREBY CERTIFY, that I attended deceased from July 1 1933, to May 18th 1934.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 26th 1897

I last saw her alive on May 14th 1934. Death is said to have occurred on the date stated above, at 7:15 P.M.

7. AGE YEARS 34 MONTHS 10 DAYS 20 If LESS than 1 day, _____ hrs. or _____ min.

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

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

Initial Insufficiency
999
999
Other contributory causes of importance: Hypertension (19)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York N.Y.

13. NAME Martin Schmepferiger

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

15. MAIDEN NAME Katarina Meyer

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

17. INFORMANT (ADDRESS) Mary E. Craig 6600 Washington Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Matthews DATE May 18 1934

19. UNDERTAKER (ADDRESS) Shepard Funeral Home 21167 Hamilton Ave.

20. FILED May 18, 1934 Lena D. Moeller Registrar.

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? Yes
If so, specify _____ (Signed) J. H. Myers, M. D.
(Address) 657 N. Grand St.

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. JUN 26 1934

