

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.

OCT 23 1935

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

(No. *4913^a*) *Palmer*

791

1003

31151

File No. *7947*Registered No. *7947*

St. Ward)

2. FULL NAME

(a) Residence, No. St. *6* 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 *Joseph Morhouser*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 13 - 1865*7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *70* *0* *8*8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *at Home*

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) *St Louis Mo*13. NAME *Peter Christian*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *France*15. MAIDEN NAME *May Young*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St Louis Mo*17. INFORMANT (ADDRESS) *Pauline Morhouser 4913^a Palm St*18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary Cemetery* DATE *9/23 1935*19. UNDERTAKER (ADDRESS) *Arthur J Donnelly 3840 Lydale Blvd*20. FILED *SEP 21 1935**J. F. Brebeck*

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 21st 1935*22. I HEREBY CERTIFY, That I attended deceased from *Sept 17 1935* to *Sept 21 1935*Last saw *in* alive on *Sept 20 1935* Death is saidto have occurred on the date stated above, at *2 A. M.*

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

*acute Cerebral Meningitis Non Epidemic*Date of onset *11/6/35*Other contributory causes of importance: *Epilepsy 85 years ago*Name of operation *none* Date ofWhat test confirmed diagnosis? *usual* 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) *H. H. Gilbert* M. D.(Address) *4123 Easton St. St. Louis*

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Eastern on