

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.

Phoned Dr. White for additional diagnosis

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

Do not use this space.

NOV 27 1935

1. PLACE OF DEATH

County *St. Louis*

Registration District No. *788*

File No. *33837*

Township *Central*

Primary Registration District No. *4471*

Registered No. *103*

City *Webster Groves* No. *907 N. Rock Hill Rd* St. *103* (Ward)

2. FULL NAME

(a) Residence, No. *907 N. Rock Hill* St. *103* Ward. *Webster Groves*

(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

F

4. COLOR OR RACE

Wh

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Edw. G. Schall

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Dec-3-1870

7. AGE

YEARS

64

MONTHS

10

DAYS

17

If LESS than 1 day, hrs. or min.

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

N.C.

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)

Mo.

MOTHER FATHER 13. NAME

Carl Meyer

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

Germany

15. MAIDEN NAME

Margaret Givinn

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

Germany

17. INFORMANT (ADDRESS)

*Edw. G. Schall
907 N. Rock Hill Rd*

18. BURIAL OR CREMATION (PERSONAL)

PLACE *St. Matthews Ant.* DATE *10/22/35*

19. UNDERTAKER (ADDRESS)

*Louis B. Boppe
Kirkwood*

20. FILED

10-21-35 Julius K. York Registrar

MEDICAL CERTIFICATE OF DEATH

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

10-20-35

22. I HEREBY CERTIFY, That I attended deceased from

July 22 to Oct. 20, 1935

I last saw him alive on *Oct. 19, 1935* Death is said

to have occurred on the date stated above, at *9 a.m.*

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

Myocarditis (chronic) Date of onset *1932*

Other contributory causes of importance

*Secondary to Pyelitis
Condition*

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

What test confirmed diagnosis?..... 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) *R. G. [Signature]* M. D.
(Address) *Kirkwood Mo.*

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