

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

Do not use this space. *✓*

13595

1. PLACE OF DEATH

County St. Louis Registration District No. 1170
 Township Central Primary Registration District No. 6248H
 City Richmond Mo. St. Mary's Hospital St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 5430 Delcor St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 76 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

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) Mar 26 1936

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Louis Trefny

22. I HEREBY CERTIFY, That I attended deceased from 3-20, 1936, to 3-26, 1936.
 I last saw h. er alive on 3-20, 1936. Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 4-59

to have occurred on the date stated above, at E. P. m.
 The principal cause of death and related causes of importance were as follows:

7. AGE YEARS 76 MONTHS 8 DAYS 22 If LESS than 1 day, _____ hrs. or _____ min.

Permeous anemia Date of onset 3/21
Coronary Thrombosis

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

Other contributory causes of importance: Pneumonia - Bronchial 3/24

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) Pennsylvania

13. NAME Louis Meyer

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Anna Zilkha
 (ADDRESS) 5430 Delcor

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Peter & Paul DATE Mar 30 1936

19. UNDERTAKER Dr. G. M. Moydell
 (ADDRESS) 1926 G. Allen

20. FILED 3/28 1936 Beatrice Porter
 Registrar.

Name of operation None Date of _____
 What test confirmed diagnosis? clinical 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? No
 If so, specify _____

(Signed) Thos M. Mathew, M. D.
 (Address) 607 No Grant

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

