

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.

NOV 4 1936

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

Do not use this space.

39539
39539

1. PLACE OF DEATH

County.....
Township.....
City **St. Louis**

Registration District No. **791**
Primary Registration District No. **1008**
American Hospital

File No. **10580**
Registered No.
St. Ward

2. FULL NAME

Adolph Jacobsmeyer

(a) Residence, No. **4142 Penrose Street** St. **10** Ward. (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 **Male** 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 **Mary E. Jacobsmeyer (Flag)**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov. 23, 1888**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
47 10 28

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

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**

FATHER 13. NAME **Frank Jacobsmeyer**

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

MOTHER 15. MAIDEN NAME **Anna Viehland**

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

17. INFORMANT (ADDRESS) **Mrs. Mary E. Jacobsmeyer 4142 Penrose Street**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Oak Grove** DATE19

19. UNDERTAKER (ADDRESS) **Math. Hermann & Son 2161 East Fair Avenue**

20. FILED **OCT 22 1936 J. F. Bredsch Registrar**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 21, 1936**

22. I HEREBY CERTIFY, That I attended deceased from **Oct 18, 1936** to **Oct 21st, 1936**
Last saw him alive on **Oct 21st, 1936** Death is said to have occurred on the date stated above, at **7:00 A. M.**

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

**Bilateral Lobes
Pneumonia**
**Chronic Interstitial
Nephritis - Myocarditis**

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? **Chrom** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **No** 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) **Walter F. Davis** M. D.
(Address) **2800 - 9 - Taylor**

Colfax 6852

