

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.

MAR 5-1937

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

Do not use this space.

1. PLACE OF DEATH

County Registration District No. **791**
 Township Primary Registration District No. **1003**
 City **St. Louis,** (No. **City Hospital No. 1**) File No. **8177**
 B. **14443** Norman Myers Registered No. **1626**
 2. FULL NAME St. **23** Ward **1**

(a) Residence, No. (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 **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **child**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Oct 3, 1933**
 7. AGE YEARS **3** MONTHS **4** DAYS **3** If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **nil**
 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, Missouri**

13. NAME **Ray Myers**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Missouri**

15. MAIDEN NAME **Catherine ? HAYES**

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

17. INFORMANT **Hosp. Info. M. H. Kent** (ADDRESS) **City Hospital No. 1**

18. BURIAL, CREMATION, OR REMOVAL PLACE **CALVARY CEM.** DATE **FEB. 8 1937**

19. UNDERTAKER **E. J. Schmyr** (ADDRESS) **8125 Lafayette Ave.**

20. **FEB 5 - 1937** 19 **J. B. Redeck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2/4/37** 19...
 22. **I HEREBY CERTIFY**, That I attended deceased from **1/5/37** to **2/4/37**, 19...
 I last saw him live on **2/4/37**, 19... Death is said to have occurred on the date stated above, at **1015p**
 The principal cause of death and related causes of importance were as follows:

acute Rheumatic Heart Disease
95
 Other contributory causes of importance:
acute Endocarditis due to Rheumatic Heart Disease

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?
 If so, specify
 (Signed) **B. Schorsch**, M. D.
 (Address) **City Hospital No. 1**

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