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.

FEB 12 1938

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

Do not use this space. 200

1. PLACE OF DEATH

(a) County ..... Registration District No. 791

(b) Township ..... Primary Registration District No. 1003 Registered No. 56

(c) City St. Louis, Mo. (d) Street No. Firmin-Desloge Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Geier Jr

(a) Residence, No. 2917 a Natural Bridge St. 10
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Rosa Geier

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) February 25th, 1875

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	10	2	

OCCUPATION

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

9. Industry or business in which work was done, as 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) Washington County, Missouri

FATHER

13. NAME Michael Geier

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

MOTHER

15. MAIDEN NAME Susan Allen

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

17. INFORMANT Mrs Rose Geier
(ADDRESS) Potosi, Missouri

18. BURIAL, CREMATION, OR REMOVAL
PLACE Potosi, Mo. DATE Dec. 29th, 1937

19. FUNERAL DIRECTOR Albert H. Hoppe Inc.,
(ADDRESS) 429 N. Euclid avenue

20. FILED JAN 3 1938 J. J. Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/27 1937

22. I HEREBY CERTIFY, That I attended deceased from 12/10 1937 to 12/27 1937

I last saw him alive on 12/27 1937. Death is said to have occurred on the date stated above, at 8.35 P m.

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

	Date of onset
Pyonephrosis & Toxemia	
no stones	
133	

Other contributory causes of importance:
Cardiac Failure caused by the Toxic condition

Name of operation Nephrectomy Date of 12/20/37

What test confirmed diagnosis? Pathologist Report 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?

If so, specify No

(Signed) L. J. McDonald, M. D.

(Address) 3125 S Grand

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)