

FEB 12 1938

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

287

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1008**
 (c) City St. Louis (d) Street No. City Hospital No. 1 Registered No. **143**
 (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.

C. 14212

2. PRINT FULL NAME

August Mayer 600
 (a) Residence, No. 884 a Canaan St. **8** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug., 15, 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 55 4 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Brick
 9. Industry or business in which work was done, as saw mill, bank, etc. layernight of work
 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) Austria13. NAME August Mayer14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria15. MAIDEN NAME unknown16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria17. INFORMANT (ADDRESS) Frank Meyer, Kent
884 Cannon Ave18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem. DATE 1-8-3819. FUNERAL DIRECTOR (ADDRESS) Edward Koch
3516 N. 14th St.20. FILED JAN 5 1938

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/4/38 . 1922. I HEREBY CERTIFY, That I attended deceased from 12/28/38, 19, to 1/4/38, 19.I last saw him alive on 1/4/38, 19. Death is saidto have occurred on the date stated above, at 9.40 a. p

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

Pulmonary tuberculosis

Date of onset

Other contributory causes of importance:

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) D. M. Maxwell, M. D.(Address) City Hospital No. 1

Brought to me signed

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

..... Licensed Embalmer No.

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