

**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 Mo.** (No. **5370**) **Pershing Ave.**, St. **6** Ward)

11093

File No.
 Registered No. **3127**

2. FULL NAME **Carrie Pfeifer Meyer**

(a) Residence. No. **5370 Pershing Ave.**, St. **12** Ward. (If nonresident, give city or town and State)
 (Usual place of abode)
 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 Female | 4. COLOR OR RACE white | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid. |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Adolph Meyer | | |
| 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 23, 1857 | | |
| 7. AGE YEARS 72 | MONTHS 6 | DAYS 3 |
| 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work At home (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer | | |
| 9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi | | |
| 10. NAME OF FATHER Moses Pfeifer | | |
| 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany | | |
| 12. MAIDEN NAME OF MOTHER Regina Frank | | |
| 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany | | |

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 26th 1930**
 17. I HEREBY CERTIFY, That I attended deceased from **16th January**, 1930, to **March 26th 1930**, that I last saw him alive on **March 26th 1930**, and that death occurred, on the date stated above, at **about 2 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-pneumonia
11A
93C
107A (duration) yrs. mos. **10** ds.
 CONTRIBUTORY **La Grippe & pneumonia**
 (SECONDARY) **as a result of**
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? **No** DATE OF
 WAS THERE AN AUTOPSY? **No**
 WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
 (Signed) **E. J. ...**, M. D.
March 27th 1930 (Address) **379 1/2 ...**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Mt. Sinai Cemetery** DATE OF BURIAL **3/28/30**
 20. UNDERTAKER **Mayer** ADDRESS **4356 Lindell.**

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.

2337
2
10

PARENTS

14. INFORMANT **Reynolds Meyer**
 (Address) **5370 Pershing**
 15. FILED **18 1930** **Max C. ...** REGISTRAR

