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

Do not use this space.

4125

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....
Township ..... Primary Registration District No. ..... Registered No. .....
City St. Louis (No. City Hospital ..... St. ..... Ward)

2. FULL NAME 1533 Charles Megl

(a) Residence. No. 2112 Dr Kalb St., 23 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 20-1928

7. AGE: Years | Months: 2 | Days: 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(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): St. Louis

PARENTS
10. NAME OF FATHER: Frank Megl
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): St. Louis
12. MAIDEN NAME OF MOTHER: Lena Stall
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): St. Louis

14. INFORMANT: Hospital Information
(Address): City Hospital

15. FILED 15, 1929 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1929, to Jan 14, 1929 that I last saw b. ... alive on Jan 14, 1929 and that death occurred, on the date stated above, at 5:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Syphilis
Broncho-pneumonia
24
107A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

1/15 (Signed) Edmund R. Sheridan M. D
, 1929 (Address) City Hospital

*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: St. Peter - Pauls | DATE OF BURIAL: Jan. 16 1929

20. UNDERTAKER: Wacker - Helderle | ADDRESS: 2331 So. Bing

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.

Negf