

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

Do not use this space.

28265

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo.* (No.) *Sanitarium* St. (Ward)

2. FULL NAME

Wilhelmina Margaret (Lancken) Meyer

(a) Residence. No. *4579 Enright*

(Usual place of abode)

13 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *33* 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)

Married

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

Oscar D. Meyer

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

Nov. 29 - 1885

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

44

8

12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Detective

(b) General nature of industry, business, or establishment in which employed (or employer)

U. S. Government

(c) Name of employer

Ed. Famous-Barr

9. BIRTHPLACE (CITY OR TOWN)

San Antonio

(STATE OR COUNTRY)

Texas

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

New York

(STATE OR COUNTRY)

14.

INFORMANT.....
(Address)

*Frederick Hohler
5400 Arsenal*

15.

FILED 14 1919

Wm C. Starbuck
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

8/11/30

19

17.

I HEREBY CERTIFY, That I attended deceased from

7/16/30

19

to *8/11/30*

19

that I last saw him alive on *8/11/30*, 19....., and that death occurred, on the date stated above, at *11:05 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dementia Paralytica (Lytic)

CONTRIBUTORY (SECONDARY)

Lues

(duration) yrs. mos. *27* ds.

(duration) yrs. mos. *27* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

No

DATE OF

WAS THERE AN AUTOPSY? *No*

No

WHAT TEST CONFIRMED DIAGNOSIS

Clinical and Laboratory

(Signed).....

Frederick Hohler

M. D.

8/11/30, 19

(Address)

5400 Arsenal

*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

DATE OF BURIAL

Friedens Cemetery

Aug 10 1930

20. UNDERTAKER

ADDRESS

Red M. Williams 4617 Delmar

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Mr. Fred McMillan
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