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.

I X16605

DEC APR 12 1939

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

8533
Do not use this space.

1. PLACE OF DEATH

(a) County 2 Registration District No. 791

(b) Township 1 Primary Registration District No. 1003 Registered No. 2298

(c) or City ST. LOUIS MO. (d) Street No. 4511 TOWER GROVE PLACE 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 326 DOLLIE METZGER.

(a) Residence, No. 4511 TOWER GROVE PLACE St. 17
(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: 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 JACOB METZGER.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN 5-1874

7. AGE: YEARS 65 | MONTHS 2 | DAYS 4 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. HOUSEKEEPER
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) MISSOURI

FATHER
13. NAME THOMAS WILLIAMS
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

MOTHER
15. MAIDEN NAME MARTHA FISCHER
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

17. INFORMANT (ADDRESS) JACOB METZGER 4511 Tower Grove Place

18. BURIAL, CREMATION, OR REMOVAL
PLACE Memorial Park DATE March 13 1939

19. FUNERAL DIRECTOR (NAME) E. J. Schmur (ADDRESS) 3125 Lafayette Av.

20. FILED MAR 1 1939 J. F. Bickick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 9 1939

22. I HEREBY CERTIFY, That I attended deceased from 12-30- 1936, to 3-9- 1939
I last saw her alive on 3-9- 1939. Death is said to have occurred on the date stated above, at 10.15 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
1. Left Hemiplegia	3/9/39
2. Hypertension caused left hemiplegia	?

Other contributory causes of importance:

828

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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 .....
(Signed) [signature], M. D.
(Address) 1310 Michigan

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Jos B Vollmer

Licensed Embalmer No. 4014

P. O. Address 325 Lafayette Ave.

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

If this body is not embalmed, above space should be left blank.