LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

37967

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 11412

City St Louis (No. 4416 North 20th St St. ..... Ward)

2. FULL NAME Henry W Bramsch

(a) Residence. No. 4416 N 20th St St., 5 Ward.
(Usual place of abode) (If nonresident give city or town and State)

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: Male
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 Minnie Bramsch

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 23rd 1843

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
80	4	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer: Phil Greiner & Bros

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER: C. W. Bramsch
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER: Charlotte Stingelager
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT: Minnie Bramsch
(Address) 4416 N 20th St

15. FILED DEC 1[illegible] 19[illegible] Max C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 17 1923

17. I HEREBY CERTIFY, That I attended deceased from one time Dec 17, 1923, to 9 AM, 1923 that I last saw him alive on Dec 17, 1923, and that death occurred, on the date stated above, at 5 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic endocarditis
1 yr
[illegible]
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic interstitial nephritis (duration) 1 yr 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? .....

129

(Signed) C E Coffee, M. D
, 19 (Address) 2407 a N Broadway

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: New Pickus Cem
DATE OF BURIAL: Dec 20 1923

20. UNDERTAKER: Fred M Williams
ADDRESS: 4561 Delmar

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.

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... .....St. .....Ward)

2. FULL NAME .....

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

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	4. COLOR OR RACE	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)

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

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

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

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9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from One time, 19 On Dec 17, 1923 that I last saw him alive on Dec 17 4 A.M., 1923, and that death occurred, on the date stated above, at 5 P.m.

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.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

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IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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