

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

8248

1. PLACE OF DEATH
 County..... Registration District No. **791**
 Township..... Primary Registration District No. **1008**
 City **St. Louis, Mo.** (No. **Sanitarium**) St. _____ Ward _____

2. FULL NAME **Thomas Frederick Roman**
 (a) Residence No. **3749 1/2 Gate Brillante Ave** **13** Ward. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred **16** yrs. + mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 **Mary Roman**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan. 18, 1890**

7. AGE YEARS **41** MONTHS **1** DAYS **9** | IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **clerk 253**
 (b) General nature of industry, business, or establishment in which employed (or employer) **Unknown**
 (c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2 - 26 - 1931**

17. I HEREBY CERTIFY, That I attended deceased from **6-1-1923** to **2-26-1931**, that I last saw him alive on **2-26-1931**, and that death occurred, on the date stated above, at **8** A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Lobar Pneumonia
 (duration) yrs. mos. da. **108**

CONTRIBUTORY (SECONDARY) **108**
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? **(1)**
 IF NOT AT PLACE OF DEATH. **0** DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____
 WAS THERE AN AUTOPSY? **no**
 WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
 (Signed) **John J. Ryan**, M. D.
2-26-1931 (Address) **5400 Arsenal St.**

*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.

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

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **John J. Ryan M.D.**
 (Address) **5400 Arsenal St.**

15. FILED **27 1931**
May E. Warden
 -REGISTRAR-

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Calvary** | **DATE OF BURIAL** **2/28 1931**

20. UNDERTAKER **Muller and Co.** | **ADDRESS** **5765 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.

