

WHITE FLANNEL—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 80931
Registrar's No. 7994

OCT 14 1939
Registration District No. 1003

Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis,
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: City Infirmary.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution November 17, 1939
Life. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri. (b) County St. Louis.
(c) City or town St. Louis, Mo. 13
(If outside city or town limits, write "RURAL")
(d) Street No. 5800 Arsenal St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. U. S. A. years

3. (a) PRINT FULL NAME Henry Mohrman
3. (b) If veteran, name war Unknown
3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced. Married
6. (b) Name of husband or wife Mary Frank Mohrmann
6. (c) Age of husband or wife if alive unk years
7. Birth date of deceased June 30, 30 1881
(Month) (Day) (Year)

8. AGE: Years 58 Months 2 Days 15
If less than one day hr. _____ min. _____

9. Birthplace St. Louis, Mo. American
(City, town, or county) (State or foreign country)

10. Usual occupation Electrician

11. Industry or business X

MOTHER FATHER
12. Name Herran Mohrmann
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Noeisch
15. Birthplace Unknown.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. Molony
(b) Address 5800 Arsenal

17. (a) Cremation (b) Date thereof Sept. 18, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Philip W. Lewis
(b) Address 4468 Washington

19. (a) SEP 16 1939 (b) J. B. Brueck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15,
year 1939 hour 1:20 minute P. M.
21. I hereby certify that I attended the deceased from November 17,
1938 to September 15, 1939
that I last saw him alive on September 15, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death:
Chronic myocarditis
cardiac failure.
Arteriosclerosis
Chronic Hypertrophic
Arteritis
Other conditions: _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work _____ (Specify type of place) _____ (e) Means of injury _____
23. Signature E. J. [Signature] (M. D. or other)
Address 5800 Arsenal

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Philip M. Gray

Licensed Embalmer No. 3281

P. O. Address 4468 Washington

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.