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

81

PLACE OF DEATH

County St Louis

Township St Ferdinand

or

Village ~~[illegible]~~

or

City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. 784 File No. 7813

Primary Registration District No. 6030 Registered No. 2-3

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John Bromwich

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word): Widower

DATE OF BIRTH: _____ (Month) _____ (Day), 1842 (Year)

AGE: 69 yrs. ___ mos. ___ ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): England

PARENTS

NAME OF FATHER: Dont Know

BIRTHPLACE OF FATHER (City or town, State or foreign country): " "

MAIDEN NAME OF MOTHER: " " "

BIRTHPLACE OF MOTHER (City or town, State or foreign country): " " "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marie Meyer Mrs Bromwich

(ADDRESS) 2122 McLaurin Ave

Filed Feby 14, 1911. J. T. Douglas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb. (Month) 13 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from ✓, 191✓, to ✓, 191✓, that I last saw h✓ alive on ✓, 191✓, and that death occurred, on the date stated above, at ✓ m.

The CAUSE OF DEATH* was as follows:

Rupture of the Aorta

96

(Duration) ✓ yrs. ✓ mos. ✓ ds.

Contributory (SECONDARY) Aneurism

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) Rolla Bracy M. D.

Feb. 13, 1911 (Address) Coroner

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Friedens Cemetery

DATE OF BURIAL: Feb. 15, 1911

UNDERTAKER: Landvogt Co

ADDRESS: Bio No 9 4 51

[illegible] in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____ (Month) _____ (Day), 1____ (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

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

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day), 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS