

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

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

1003

Township.....

Priority Registration District No.....

City.....

*St. Louis*

(No.....)

*St. Johns Hospital*

St.....

Ward.....

File No. **19663**  
Registered No. **5568**

**2. FULL NAME**

*Roger E. Gorman*

(a) Residence. No.....

(Usual place of abode)

*4963 Page*

St.....

Ward.....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs..... mos.....

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)

*Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

*Unknown 1863*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

*abt 64*

8. OCCUPATION OF DECEASED

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

*467 Clerical Work 7.4 A*

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

*St. Louis*

10. NAME OF FATHER

*Patrick Gorman*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Ireland*

12. MAIDEN NAME OF MOTHER

*Jane Brady*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Ireland*

14.

INFORMANT

(Address)

*Mrs. Ella Ryan*

*4357 1/2 Maryland*

15.

FILED

19

*JUN 10 1927*

*Mar C Starkeoff*

REGISTRAR

**2. MEDICAL CERTIFICATE OF DEATH**

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

*4/9*

19*27*

17.

I HEREBY CERTIFY, That I attended deceased from

*5/2/27* 19*27* to *6/9/27* 19*27* and that I last saw him alive on *6/9/27* 19*27* and that death occurred, on the date stated above, at *9:00* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Coronary lesion*  
*Alcoholic*  
(duration) yrs. *6* mos. ds.

CONTRIBUTORY (SECONDARY)

*Coronary lesion*

(duration) yrs. *2* mos. ds.

18. WHERE WAS DISEASE FIRST DETECTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH... *no* DATE OF

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *OS/Falk* M. D.  
*6/10/27* (Address) *Univ Club Bldg*

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

*laboratory*

*6-11 1927*

20. UNDERTAKER

ADDRESS

*Arthur J. Donnelly, 2039 Wash St*

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.

MISSOURI STATE BOARD OF HEALTH

1000 St Johns Hospital