

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

Do not use this space.

38269

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo (No. 5633 N. Magnolia Ave)
 Registered No. 10314 St. _____ Ward _____

2. FULL NAME

Lorenz Gramann
 (a) Residence. No. _____ St. B 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. 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 16th 1895

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
32 5 19

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Jewelry Clerk
 (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 Mo.

10. NAME OF FATHER Berhard Gramann

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

12. MAIDEN NAME OF MOTHER Josephine Albers

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

14. INFORMANT Berhard Gramann
 (Address) 5633 N. Magnolia Ave

15. FILED DEC -6 1927 Max C. Starkloff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5th 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18th 1927 to Dec 5th 1927 that I last saw him alive on Dec 4th 1927, and that death occurred, on the date stated above, at 12:45 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
 (duration) 8 yrs. _____ mos. _____ da.
 CONTRIBUTORY (SECONDARY) none
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) L. E. Wiluadi, M. D.
 , 19 (Address) 5402⁹ Gravois Ave

*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 St Peter & Pauls, C. DATE OF BURIAL Dec 7th 1927

20. UNDERTAKER J. H. Gebker L. & Co ADDRESS 2628 Gravois Ave

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.

PERMANENT RECORD

11.

CONTINUING INK

In view of the fact that the
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