

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

Do not use this space.

15035

**1. PLACE OF DEATH**

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis

(No. 220 7 1/2 Main St)

File No. ....

Registered No. 13952

St. ....

Ward) .....

**2. FULL NAME**

Frederick Brommelhorst

(a) Residence. No. 3957 Oakland, St. 10 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. 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April. 31 1869

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>58</u>	<u>11</u>	<u>18</u>	

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Wm. Brommelhorst

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

12. MAIDEN NAME OF MOTHER Not Known

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

14. INFORMANT Sophie Brommelhorst  
(Address) 3957 Oakland

15. FILED APR 19 1934 W. C. Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9 1928

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....  
That I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... about 8 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Aortic Stenosis & Insufficiency  
92 P (duration) yrs. mos. ds.  
Coronary Sclerosis  
(SECONDARY) (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY..... yes

WHAT TEST CONFIRMED DIAGNOSIS.....  
(Signed) J. W. Kerner, M.D.

4/10, 1928 (Address) Dep. Coroner

\*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. Johns. Park DATE OF BURIAL Apr. 12 1928

20. UNDERTAKER Wm. F. Paschdag ADDRESS 3825 No. Grand

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

