

7 1928

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

Do not use this space.

1. PLACE OF DEATH  
 County St. Louis Registration District No. 1170 File No. 21811  
 Township Richmond Heights Primary Registration District No. 6248 H Registered No. 149  
 City St. Marys Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Peter R. Gorman  
 (a) Residence No. 5236 Maple St. \_\_\_\_\_ Ward \_\_\_\_\_ St. Louis, Mo.  
 (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) Widowed

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
About 70

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work Clerical Work  
 (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) Mo.

10. NAME OF FATHER Unknown Gorman

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

12. MAIDEN NAME OF MOTHER r y

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

14. INFORMANT Aidan J. Gorman  
 (Address) 5236 Maple

15. FILED 6/22 19. 28 6248 H REGISTRAR

## 3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/21 1928

17. I HEREBY CERTIFY, That I attended deceased from 28 May 1928, to 21 June 1928 that I last saw him alive on 21 June 1928, and that death occurred, on the date stated above, at 12 noon m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pulmonary Embolism

Fracture Femur  
Extracapsular (near)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED \_\_\_\_\_

(Signed) Arthur J. Donnelly M. D.

6/22, 19 (Address) 2039 9th St.

\*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 Calvary DATE OF BURIAL 6-23 1928

20. UNDERTAKER Arthur J. Donnelly ADDRESS 2039 9th St.

Stamps Hospital

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.  
 County St. Louis Registration District No. 1170 File No. ....  
 Township Richmond Heights Primary Registration District No. 6248 # Registered No. 149  
 City Richmond Heights No. .... St. .... Ward) .....

2. FULL NAME Peter R. Lorman  
 (a) Residence. No. .... St. .... 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

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

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

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

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 21 1928

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pulmonary Embolism  
Fracture caused by fall.  
 (duration) yrs. mos. ds.  
 CONTRIBUTORY Fractured femur  
 (SECONDARY) extracapsular (neck) (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? .....  
 WHAT TEST CONFIRMED DIAGNOSIS? .....  
 (Signed)....., M. D.  
 , 19 (Address)

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 8/7 1928 G L Jensen REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
 ADDRESS 19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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