

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. **791**
Primary Registration District No. **1003**

File No. **22622**
Registered No. **6881**
St. Ward)

2. FULL NAME

George Elmer Landmann

(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 *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) *Feb 12, 1928*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
0 4 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *none*
(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)

PARENTS

10. NAME OF FATHER *Oscar H Landmann*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Missouri*

12. MAIDEN NAME OF MOTHER *Elmer Werner*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Missouri*

14. INFORMANT *Oscar Landmann*
(Address) *8571 Idaho*

15. FILED *111 -1 1928* May 11 1928 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 30 1928*

17. I HEREBY CERTIFY That I attended deceased from *June 30 1928* to *June 30 1928*
that I last saw him alive on *June 30 1928*, and that death occurred, on the date stated above, at *2:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
107A

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

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

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? *No.*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*

(Signed) *H. R. Rind*, M. D.

6/30 1928 (Address) *8208 Alabama*

*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

St. Trinity Lutheran *7/1 1928*

20. UNDERTAKER ADDRESS

W. Hoffmeister & Co *7814 So. Bldg*

**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
Towship St. Louis
City St. Louis (No.)

Registration District No. 791
Primary Registration District No. 1003

File No.
Registered No. 6851
St. Ward)

2. FULL NAME

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 30 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:

Prophylactic pneumonia
Primary, information given over
phone by St. H. Rund, Sec. of H.S.
8-14-28
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) (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?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.
, 19 (Address)

*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

20. UNDERTAKER ADDRESS

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

REGISTERED

S-22622