

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

Do not use this space.

35299

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *6315 Henry*)

File No. ....

Registered No. **10286**

St. .... Ward)

**2. FULL NAME** *Herman Rockenbrodt*

(a) Residence. No. *6315 Henry* St., *N* 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 *Rose Rockenbrodt*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 10-1871*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
*57 | 3 | 9*

**8. OCCUPATION OF DECEASED**

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

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

(c) Name of employer

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

10. NAME OF FATHER *Hy Rockenbrodt*

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

12. MAIDEN NAME OF MOTHER *Antenow*

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

14. INFORMANT *Rose Rockenbrodt* (Address) *6315 Henry St*

15. FILED *20* 19*28* *max b Stadsoff* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 19* 19 *28*

17. I HEREBY CERTIFY, That I attended deceased from *10-17*, 19*28*, to *10-19*, 19 *28* that I last saw him alive on *10-18*, 19 *28* and that death occurred, on the date stated above, at *1:30* p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Cerebral Hemorrhage*  
*92A*  
*740*

CONTRIBUTORY (SECONDARY) *740* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? *no at home*

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

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *none*

(Signed) *H. Schmemmer*, M. D.

*10/19*, 19 *28* (Address) *6811 9 Gravois*

\*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 *New St Marcus* DATE OF BURIAL *Oct 22* 19 *28*

20. UNDERTAKER *Wacker-Heldorfs* ADDRESS *2331 S Blum*

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.

WRITE PRINTING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

