

JAN 28 1928

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

Do not use this space.

42461

1. PLACE OF DEATH

County Richmond Registration District No. 1170
Township W Primary Registration District No. 6248H File No. _____
City St. Louis Co. (No. St. Marys Hospital) Registered No. 276 St. _____ Ward _____

2. FULL NAME

Herman J. Bromschiug
(a) Residence. No. 1217 Goodfellow 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 20-1910

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
18 2 17

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Student
(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 Herman H. Bromschiug

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

12. MAIDEN NAME OF MOTHER Clara Remmers

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

14. INFORMANT Herman H. Bromschiug (Address) 1217 Goodfellow

15. FILED 12/8 19. 28 CB Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 28 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1928 to Jan 28 1928 that I last saw him alive on Jan 23 1928, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
1215
127 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Alcoholism (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. 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 Calvary Cem. DATE OF BURIAL 12-10 1928

20. UNDERTAKER Bromschiug Und. ADDRESS 4718 West Florissant

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.

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