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

Do not use this space.

35537

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

File No. .....

Registered No. 10288

City St, Louis Mo. (No. ....., Jewish Hospital. St. ..... Ward)

2. FULL NAME Robert Portmann Jewish Hospital.

(a) Residence. No. 4260 Harris. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male.	White.	Infant.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-2-1928

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

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) St, Louis Mo.

PARENTS

10. NAME OF FATHER Walter F. Portmann.

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

12. MAIDEN NAME OF MOTHER Blanch Girard

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

14. INFORMANT Walter F. Portmann
(Address) 4260 Harris

15. FILED OCT 21 1929 19 Max C. Tonkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 19 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1929, to Oct. 19, 1929 that I last saw him alive on Oct 19, 1929 and that death occurred, on the date stated above, at 8 20 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

119B Anhydraemia
69B Diarrhoea
189

..... (duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (SECONDARY) Acidosis

..... (duration) ..... yrs. ..... mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

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

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) John A. Raich, M. D.

, 19 (Address) Jewish Hospital

*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 Peters	10-21- 1929
20. UNDERTAKER	**ADDRESS**
Provost Und Co	3710 N Grand

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

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 ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 10288

City St Louis (No. ..... St. ..... Ward)

2. FULL NAME Robert Portmann

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

PARENTS
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 DEC 21, 1929 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 19 1929

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 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Anhydremia - Diabetes
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Acidosis Non Diabetic Information given over Phone by Sec Raisch Div of U. S.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 12-18-29
DID AN OPERATION PRECEDE DEATH? DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ..... M. D.
, 19 (Address)

1136

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

1929
35537