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

Do not use this space.

41910

File No. .....

Registered No. .....

1. PLACE OF DEATH

County St. L. County

Township St. Ferdinand

City ~~Florissant~~ (No. ....., ... St. ..... Ward)

Registration District No. 784

Primary Registration District No. 1.5.3.0

2. FULL NAME ~~J[illegible]~~ ELIZABETH HOORMANN

(a) Residence. No. Florissant Mo. 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: FEMALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): ✓

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

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

7. AGE: YEARS | MONTHS | DAYS 4 | 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) Florissant
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER JOHN R. HOORMANN

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

12. MAIDEN NAME OF MOTHER Adelheide Willen

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

14. INFORMANT .....
(Address) .....

15. Filed Jan 15th 1930 O. M. Schudde
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec - 24 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 24th 1929, to Dec 24 1929 that I last saw her alive on Dec 24 1929, and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
(Premature) 6 month gestation, Partial separation of placenta due to sudden fainting two weeks ago. 8 hrs
(duration) ..... yrs. ..... mos. ..... ds.

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

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

(a) DID AN OPERATION PRECEDE DEATH? No DATE OF ✓

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Roy Johnson, M. D
, 19 (Address) Ferguson, Mo.

*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

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 PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

4 24 1930 96 9 3