

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

Do not use this space.

6826

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis (No. City Improv) St. _____ Ward _____

File No.....
Registered No. 1662
St. _____ Ward _____

2. FULL NAME

Fritz Bernmann
(a) Residence. No. 5538 Green - Ave St. 6 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) Widowed

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. L. Bernmann

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 14 - 1860

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
69 6 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY)

10. NAME OF FATHER Carl Bernmann

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

12. MAIDEN NAME OF MOTHER Bernmann

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

14. INFORMANT W. L. Bernmann
(Address) 5538 Green - Ave

15. FILED 19 _____ 19 _____
REGISTRAR W. L. Bernmann

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-15-30

17. I HEREBY CERTIFY, That I attended deceased from 1-1, 1930, to 2-15, 1930 that I last saw him alive on 2-14, 1930 and that death occurred, on the date stated above, at 12:15 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
108
93C
(duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED 1010
IF NOT AT PLACE OF DEATH _____

18 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) W. L. Bernmann, M. D.

2-15-30 (Address) 1500 annual

*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 St. Peters DATE OF BURIAL Feb 15 19 30

20. UNDERTAKER Edw. F. Howard & Son ADDRESS 4212 St. Louis Ave

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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