

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

Do not use this space.

6952

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **2838** Magnolia St. Ward)

File No.....
Registered No. **1811**
St. Ward)

2. FULL NAME

William Alexander Ramming
(a) Residence. No. **2838 Magnolia** St., **24** 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 **Dorothea C. Ramming**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Mar 10 - 1898**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 11 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **mfg**
(b) General nature of industry, business, or establishment in which employed (or employer) **Machinists Equip**
(c) Name of employer **Self**

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

10. NAME OF FATHER **John Ramming**

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

12. MAIDEN NAME OF MOTHER **Anna K. Barfoss**

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

14. INFORMANT **Dorothea C. Ramming**
(Address) **2838 Magnolia**

15. FILED **21** 19 **May** **C. Starke** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2-18 1930**

17. I HEREBY CERTIFY, That I attended deceased from **10/1** 19**30**, to **2/18** 19**30**, and that I last saw him alive on **2/18** 19**30**, and that death occurred, on the date stated above, at **8:30** P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Terminal dobar Pneumonia (8 days)
Multiple abscess Brain
Chronic Toxicemia infection non
Chronic Myocarditis, Aspiration of cause unknown
(duration) **10** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Abscess of Brain from infection**
cause unknown (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

20. WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **Lab + X Ray**

(Signed) **P. J. Paugh** M. D.

219 126 (Address) **442 N. Euclid**

*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 Cem** DATE OF BURIAL **2-21 1930**

20. UNDERTAKER **Weick Bros** 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.

10-1-63

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