

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

Do not use this space.

~~2188~~
20990

1. PLACE OF DEATH

County..... Registration District No. **791¹
1003**
Township..... Primary Registration District No.....
City **St. Louis** (No. **City No. 10624**)

File No.....
Registered No. **5815**
St..... Ward.....

2. FULL NAME

William Hermann (HARMANN)
(a) Residence. No. **2839 Lemp** 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. **27** da. 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** *Single*
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 23 1930*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
21

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *none*
(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.*

10. NAME OF FATHER *William Hermann*

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

12. MAIDEN NAME OF MOTHER *Margaret Brennan*

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

14. INFORMANT *William C. Parker*
(Address) *City St. Louis*

15. FILED 19 *1930* REGISTRAR *Wm C. Parker*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 14 1930*

I HEREBY CERTIFY, That I attended deceased from *June 12 1930* to *June 14 1930* that I last saw him alive on *June 14 1930*, and that death occurred, on the date stated above, at *2:45 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cellulitis of Penis, Scrotum, legs and back following Circumcision due to the Staphylococcus
(duration) _____ yrs. mos. ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. ds.

18. WHEN WAS DISEASE CONTRACTED *1530*
IF NOT AT PLACE OF DEATH DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *5/29/30*
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *clinical*
(Signed) *Edward Melby*, M. D.
15-1930 (Address) *City St. Louis*

*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. Peter & Paul* DATE OF BURIAL *June 16 1930*

20. UNDERTAKER *J. H. Gebken* ADDRESS *2630 Grand*

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.

Hermann