

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

Do not use this space.

1. PLACE OF DEATH

County.....
 Township.....
 City.....

Registration District No. **791**
 Primary Registration District No. **1003**

25274
 File No.
 Registered No. **7503.**
 St. Ward)

2. FULL NAME

(a) Residence. No. **330 Hoffmeister Ave** St. **24** Ward. **St. Louis County, Mo.**
 (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 Lucille Grompe

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 3 1888

7. AGE
 YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
 42 6 22

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Retired Sailor
 (b) General nature of industry, business, or establishment in which employed (or employer). U. S. Navy
 (c) Name of employer

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

10. NAME OF FATHER Frederick Grompe

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

12. MAIDEN NAME OF MOTHER Teresa Hackett

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

14. INFORMANT Miss Anna Grompe
 (Address) 330 Hoffmeister Ave.

15. FILED L 26, 1933
 May 20 1933
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 1930

17. I HEREBY CERTIFY That I attended deceased from **1003 Alexander Bldg Hospital**, 19..... to..... 19.....
 that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at..... 3:15 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
 Gun Shot Wound Abdomen
 173

(duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

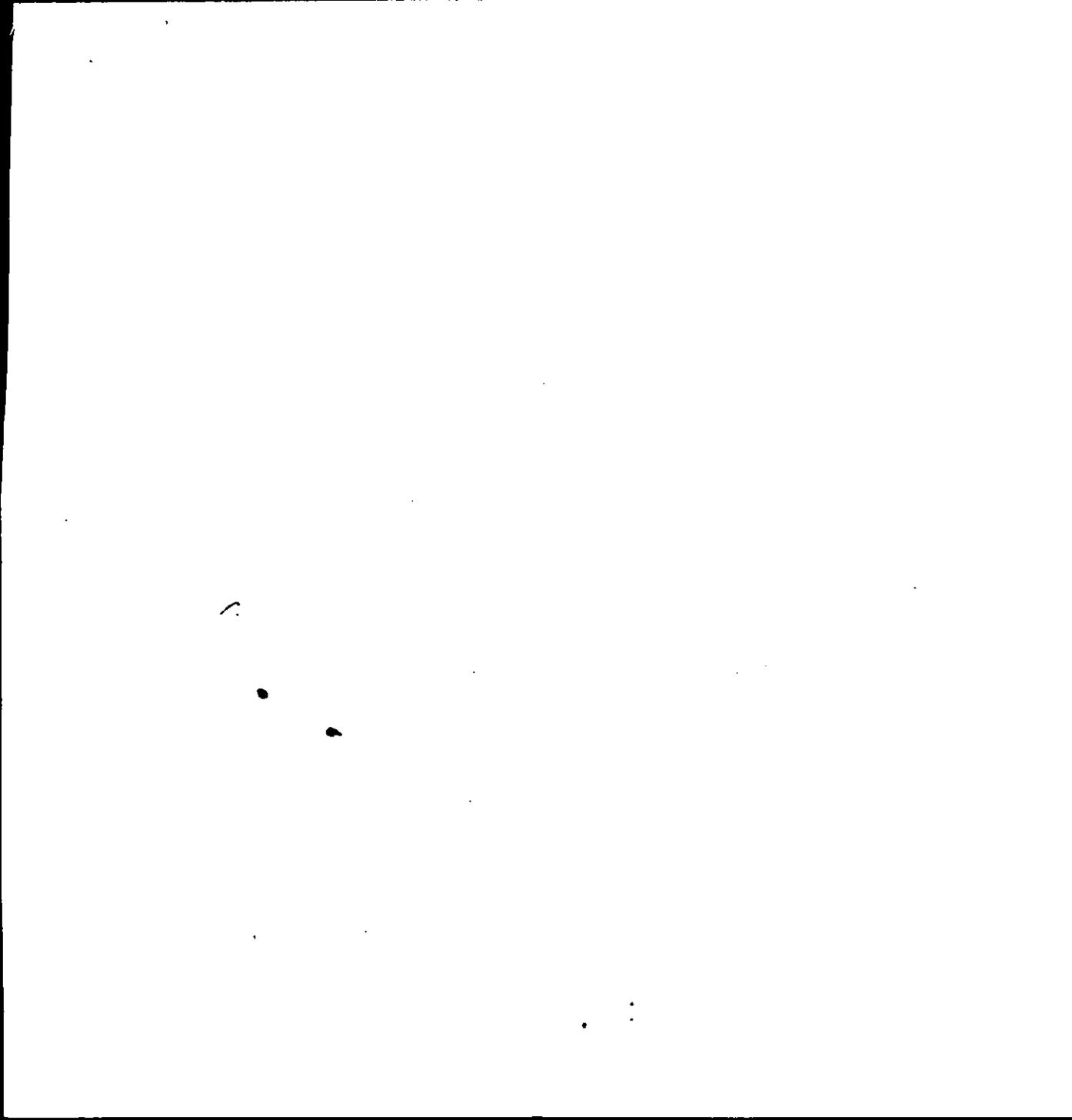
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. W. Home M.D.
 7/26 1930 (Address) Dep. Cor.

*State the DISEASES 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 Mt. Olive Cem.
DATE OF BURIAL 7/28 1930

20. UNDERTAKER C. Hoffmeister & Co 284 S Broadway



5-25-74