

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

Do not use this space.

31655

**1. PLACE OF DEATH**

County..... Registration District No.....  
Township..... Primary Registration District No.....  
City St. Louis Mo. (No. Sanitarium) St. \_\_\_\_\_ (Ward)

File No. \_\_\_\_\_  
Registered No. 9307

**2. FULL NAME**

John Domann, Sr.  
(a) Residence No. 3970 Bradford St., \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 35 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 Josephine Domann

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
About 68 Unknown

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Florist 136 66  
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown  
(c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT W.F. McNamee M.D.  
(Address) 5400 Arsenal

15. FILED 19 11 May C. J. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 25<sup>th</sup> 19 20

17. I HEREBY CERTIFY, That I attended deceased from July 1<sup>st</sup> 19 20 to Sept 25<sup>th</sup> 19 20 that I last saw him alive on Sept 24<sup>th</sup> 19 20, and that death occurred, on the date stated above, at 3:05 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Toxemia from Urthelial abscess rupturing into perineum

(duration) \_\_\_\_\_ yrs. mos. 3 ds. +  
CONTRIBUTORY surgical shock  
(SECONDARY) (duration) \_\_\_\_\_ yrs. mos. 1 ds. +

18. WHERE WAS DISEASE CONTRACTED 1514 12 2  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 9/24/20  
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Findings  
(Signed) W.F. McNamee M. D.

9/25, 19 20 (Address) 5400 Arsenal St

\*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 Sr. Marcus DATE OF BURIAL 9-27 19 20

20. UNDERTAKER W. C. Moydell ADDRESS 1926 Allen

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.

