

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

Do not use this space.

20082

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1005**
City **St. Louis** (No. **St. Johns** **Keop**)

File No. **6117**
Registered No. **6117**
St. Ward)

2. FULL NAME

(a) Residence. No. **6022 Maple** St. **6** Ward. (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 **bernie Robert Romanach**
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 12, 1877**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 11 18
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. **Salesman 19th**
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY)
10. NAME OF FATHER **Jacob Romanach**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Russia** (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER **Rosa Glass**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Russia** (STATE OR COUNTRY)

14. INFORMANT **Mrs. Bernice Romanach** (Address) **6022 Maple**

15. FILED **23 1931** REGISTRAR **W. C. Barber**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 30 1931**
17. I HEREBY CERTIFY, That I attended deceased from **22** **May** 1931, to **May 30** 1931 that I last saw h. **alive** on **May 27** 1931, and that death occurred, on the date stated above, at **5:36 a** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia
107A
(duration) yrs. mos. **4** ds.

CONTRIBUTORY (SECONDARY) **107A**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH **no**
DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFIRMED DIAGNOSIS **X Ray Chest Exam**
(Signed) **Chas. Miller** M. D.
5/30/31 (Address) **1035 Mission**
*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 **Mr. Shive Heb** DATE OF BURIAL **5/31 1931**

20. UNDERTAKER **W. C. Berger** ADDRESS **715 McPherson**

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.

1877

1878

1879