

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

Do not use this space.

30679

791
1003B

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No. *Em. Route City Hospital #1*) St. Ward)

File No. **8351**
Registered No.....

2. FULL NAME

Henry G. Draymann

(a) Residence, No. *3225 Montgomery St.* Ward. *11*

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Mary Draymann</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Jan. 16 1897</i>		
7. AGE YEARS <i>55+</i>	MONTH <i>7</i>	DAYS <i>29</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Mechanic 63</i>		11. Total time (years) spent in this occupation.....
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>Refrigerators</i>		
10. Date deceased last worked at this occupation (month and year).....		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 15, 1932*

22. I HEREBY CERTIFY, That I attended deceased from *No Physician in attendance*

I last saw him..... alive on....., 19..... Death is said

to have occurred on the date stated above, at *11:45* a.m.

The principal cause of death and related causes of importance were as follows:

93 Ch. Myocarditis

Other contributory causes of importance:

BC 7

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

13. NAME *Henry Draymann*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany 10*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT *Mary Draymann* (ADDRESS) *2009 - Decoto Ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Weston Rubin* DATE *9-19 1932*

19. UNDERTAKER *W. A. Stark and Co* (ADDRESS) *211 E. 2nd St*

20. FILED *SEP 17 1932* *W. C. Powell* Registrar

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *W Injury*
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify..... (Signed) *J. W. Kemmer*, M. D.
Dr. Cornin (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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

