

NOV 16 1938

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

34051

Do not use this space.

## 1. PLACE OF DEATH

(a) County..... Registration District No. **791**  
(b) Township **St Louis** Primary Registration District No. **1003**  
(c) City..... (d) Street No. **City Hospital #1** Registered No. **9037**  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.  
(If death occurred in Hospital or Institution, write its name instead of street and number)

## 2. PRINT FULL NAME

**655 Henry Grohmann**  
(a) Residence, No. **3986 Tholozan** St. **16**  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **October 24 1868**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**69 11 20**

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Laborer**  
9. Industry or business in which work was done, as saw mill, bank, etc. **(Unemployed 30 years)**  
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

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

FATHER 13. NAME **Wm Grohmann**  
14. BIRTHPLACE (CITY OR TOWN) **Germany** (STATE OR COUNTRY) **Mo**

MOTHER 15. MAIDEN NAME **Anna Megue**  
16. BIRTHPLACE (CITY OR TOWN) **Germany** (STATE OR COUNTRY) **Mo**

17. INFORMANT **Osce Grohmann** (ADDRESS) **3986 Tholozan**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St Trinity Cem** DATE **Oct 17, 1938**

19. FUNERAL DIRECTOR (NAME) **Beiderwieder Funl Home** (ADDRESS) **1936 St Louis Ave**

20. FILED **OCT 17 1938** **J. H. Bredeck** Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct. 14**, 19**38**.

22. I HEREBY CERTIFY, That I attended deceased from **Apr. 10**, 19**38**, to **Oct. 14**, 19**38**.

I last saw him alive on **Oct. 14**, 19**38**. Death is said to have occurred on the date stated above, at **11.10 P.M.**

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

**Bilateral Bronchopneumonia**  
**Uremia**  
**non-calculous**

Date of onset

**3 weeks**

Other contributory causes of importance:

**Chronic Myocarditis**

Name of operation **Autopsy** Date of **11/13/38**  
What test confirmed diagnosis? **Gst. cap.** 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.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
If so, specify.....

(Signed) **J. H. Bredeck**, M. D.  
(Address) **City Hospital #1**

STATE OF ILLINOIS  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH SERVICES

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 3497

P. O. Address 1936 St. Louis

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**