

Registration District No. **704**

Primary Registration District No. **20**

Registrar's No. **1666**

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Natural Bridge Road.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME OTTO HERRMANN. **1.55**

3. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lisett Herrmann 6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased February 15, 1857
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>6</u>	<u>19</u>	hr. _____ min. _____

9. Birthplace Baden, Germany.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Tailor.

11. Industry or business _____

MOTHER { 12. Name Dont Know **9**
 FATHER { 13. Birthplace Dont know (State or foreign country)
 { 14. Maiden name Dont know
 { 15. Birthplace Dont know (State or foreign country)

16. (a) Informant Mr. William Herrmann.

(b) Address Route 7 Box 389 Overland, Mo.

17. (a) Burial (b) Date thereof 9-3-1940.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Geo. L. Pleitsch Inc.

(b) Address 5966-68 Easton Ave.

19. (a) SEP - 4 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town Overland
(If outside city or town limits, write "RURAL")
 (d) Street No. Route 7 Box 389
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? 60 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 3rd.
 year 1940 hour 9 minute 10 A.M.

21. I hereby certify that I attended the deceased from Nov 3, 1939
 _____, 19____, to 9-3, 1940

that I last saw him alive on 9-3, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Parasitosis of Liver. **Duration 8 mo.**

Due to _____

Due to _____

Other conditions Myocarditis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

704
 While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address 962 1/2 Maple Date signed 9-3-40

Duration
 8 mo.
 Physician
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. J. H. H. Coe
9621 Larchwood rd.

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

Leonard W. Truquet, Registered Apprentice No. _____
working under my personal supervision.

Signed Leonard W. Truquet

Licensed Embalmer No. 2678

P. O. Address St Louis, Mo

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7
State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 1666-

1. PLACE OF DEATH:

(a) County St. Louis Rural
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Otto Herrmann

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
h..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept. day 3 - 40 -
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature Herman Kloecker M.D. (M. D. or other).....

Address 9621 Lackland Rd. Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-29750