

FILED JUL 8 1944 8

Registration District No. 8 1944 8

Primary Registration District No. 1003

Registrar's No. 5754

1. PLACE OF DEATH:
(a) County.....
(b) City or town..... St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DePaul Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 1 mo (Specify whether
years, months or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State..... Mo (b) County St Louis
(c) City or town..... Overland
(If outside city or town limits, write "RURAL")
(d) Street No. 10525 Olmstead
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert R Herman

3. (b) If veteran, name war None 3. (c) Social Security No. 498-10-7644

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Mary Lee Herman 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Nov 27 1897
(Month) (Day) (Year)

8. AGE: Years 46 Months 6 Days 28 If less than one day hr. min.

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

10. Usual occupation Service Station Attendant

11. Industry or business Filling Station

MOTHER FATHER

12. Name Joseph Herman

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

14. Maiden name Melody Castlen

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

16. (a) Informant William Herman

(b) Address Crows Coeur Mo

17. (a) Burial (b) Date thereof 6/28/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director Ortmann Funeral Home

(b) Address 8222 Jackland Overland Mo

19. (a) JUN 27 1944 (Date received local registrar) (b) J. P. Brebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25 year 1944 hour 6:30 minute PM

21. I hereby certify that I attended the deceased from April 15 1944 to July 15 1944
that I last saw him alive on 6/15/44 and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus (Wenderson) Septicemia Duration 2 mo.

Due to Streptococcus Septicemia
Due to Septicemia

Other conditions Nephritis, acute
(Include pregnancy within 3 months of death)

Major findings: Nephritis, acute PHYSICIAN

Of operations None
Of autopsy Yes
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) no
(b) Date of occurrence no
(c) Where did injury occur? no (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) (c) Means of injury no

23. Signature Quinn: Thoms (M. D. or other) M.D.
Address 6155 Parkway Shreveport La signed 6/16/44

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

0-2
5-43
7-39
X36671

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

Al C. Ortman

Licensed Embalmer No. *3478*

P. O. Address

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, fact should be so stated above.