

No. 300
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 7 1948
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7448

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: St. Johns Hospital 0
(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 Henry John Korman
3. (b) If veteran, No 3. (c) Social Security No. None

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Addie Pearl Korman 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased September 21 1865
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days 3 If less than one day hr. _____ min. _____

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name William Korman 11
13. Birthplace Germany 1
(City, town, or county) (State or foreign country)
14. Maiden name Alveda Flott
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Addie Korman
(b) Address Mineola, Mo.

17. (a) Burial (b) Date thereof 8-27-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Montgomery City, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) AUG 25 1948 (b) J. Z. Brodeur
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery 70
(c) City or town Mineola 0
(If outside city or town limits, write "RURAL")
(d) Street No. N.R. 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 24
year 1948 hour 11 minute 50 P.M.
21. I hereby certify that I attended the deceased from July 22nd, 1948, to Aug 24, 1948.
that I last saw him alive on Aug 24, 1948.
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolus
Due to Thrombophlebitis
Due to Benign Prostatic Hypertrophy
Other conditions 83
(Include pregnancy within 3 months of death)
Major findings: Benign Prostatic Hypertrophy
Of operations _____
Of autopsy _____
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 X
(c) Where did injury occur? X (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) Means of injury _____

23. Signature Grayson Carroll (M. D. or other)
Address Humboldt, Mo. Date signed 8/24

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.....

Frank J. Hyland

Licensed Embalmer No.....

264E

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, fact should be so stated above.