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MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **38248**  
Registrar's No. **10072**

FILED DEC 2 1948  
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
911 Warren St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 69 years (Specify whether years, months or days)

3: (a) PRINT FULL NAME Otto W. Homann.

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male 5. Color or race white

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

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

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased October 8th, 1879  
(Month) (Day) (Year)

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

69 1 12 hr. min.

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

10. Usual occupation retired

11. Industry or business Rudolph Homann

MOTHER FATHER { 12. Name Rudolph Homann

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

14. Maiden name Lena Essmann

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

16. (a) Informant Winona Homann

(b) Address 911 Warren St.

17. (a) Cremation (b) Date thereof 11-22-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Hy. Leidner U. Co.

(b) Address 2223 St. Louis Ave.

19. (a) NOV 21 1948 (b) J. B. Lancaster  
(Date received local file) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 911 Warren St.  
26 (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 20th  
year 1948 hour 10.00 AM minute \_\_\_\_\_

21. I hereby certify that I attended the deceased from Sept. 1948  
to Nov. 1948  
that I last saw him alive on Nov. 18, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebro-vascular accident

Due to Hypertension Duration 4 yrs

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_

(c) Means of injury \_\_\_\_\_

23. Signature Maxwell H. Bierman (M. D. or other) \_\_\_\_\_

Address 1126 St. Louis Ave Date signed 11/20/48

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**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 John P. Buchholz  
Licensed Embalmer No. 1674  
P. O. Address 2223 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, fact should be so stated above.**