

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St Louis** (No. **City Hospital**)

File No. **28892**
Registered No. **F 8449**
St. Ward)

2. FULL NAME

(a) Residence. (No. **4011 W. Jones St.**, Ward. **19**)
(Usual place of abode)

Length of residence in city or town where death occurred **33** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** | 4. COLOR OR RACE **white** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 7 - 1876**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 | 7 | 14

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Banker.**
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **New York**

10. NAME OF FATHER **John Brundtke**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **New York**

12. MAIDEN NAME OF MOTHER **Margaret Ellis**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **New York**

14. INFORMANT (Address) **City Hospital**

15. FILED **SEP 22 1927** REGISTRAR **Max C. Starbuck**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 21 1927**

17. I HEREBY CERTIFY That I attended deceased from **Sept 16**, 19**27** to **Sept 21**, 19**27** and that I last saw him alive on **Sept 16**, 19**27** and that death occurred, on the date stated above, at **10:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
**Chronic myocarditis
General Septicemia**

CONTRIBUTORY (SECONDARY) **Infection in left leg**

18. WHERE WAS DISEASE CONTRACTED **Infection unknown**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

19. WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **J. H. Stapp**, M.D.
(Address) **City Hospital**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **POTTERS FIELD.** DATE OF BURIAL **9-23-1927**

20. UNDERTAKER **C. Shannon** ADDRESS **2222 Clark**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD

Bundles