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 File No. 32199

Township ..... Primary Registration District No. 1003 Registered No. 9606

City St Louis (No. 5367 Arsenal St. ..... St. ..... Ward)

2. FULL NAME Michael Brenner

(a) Residence. No. 5367 Arsenal St., 13 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown 1861

7. AGE: Abt. 66 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

PARENTS
10. NAME OF FATHER: John Brenner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: Mary Brenner
(Address) 5367 Arsenal St

15. FILED OCT 27 1927, 19 Max C Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 26 1927

17. I HEREBY CERTIFY, That I attended deceased from Mar 21, 1927, to Oct 26, 1927 that I last saw him alive on Oct 25, 1927, and that death occurred, on the date stated above, at 1 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Rectum
46D
45
(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) H. H. Newland, M.D.
, 19 (Address) 6460 Southwest Av

*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: S S Peter & Paul Cemetery
DATE OF BURIAL: Oct 28 1927

20. UNDERTAKER: Kriegshauser Und. Co.
ADDRESS: 4104 Manchester av

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD