

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

Do not use this space.

2525

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis Mo. (No. City Sanitarium)** St. Ward

File No.
 Registered No. **65** St. Ward

2. FULL NAME

Carl Brockelmeyer
 (a) Residence. No. **8824 Wenden Pl., 13** Ward. **St. Louis County Mo.**
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 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) **Widowed**

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hra. ormin.
About 79

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Unknown**
 (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) **Germany**

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

"

14.

INFORMANT **William T. Gaitler M.D.**
 (Address) **5300 Arsenal St.**

15.

FILED **1928** **Mar 6 Starckoff**
 REGISTERED

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 2 1928**

17. I HEREBY CERTIFY, That I attended deceased from **Dec 28**, 19**27**, to **Jan 2**, 19**28** that I last saw deceased, alive on **Jan 1**, 19**28**, and that death occurred, on the date stated above, at **7:05 a.m.**

18A THE CAUSE OF DEATH* WAS AS FOLLOWS:
194R Chronic myocarditis
92C

185 (duration)..... yrs. mos. **6** ds. +

CONTRIBUTORY **Impacted transverse fracture of left femur** (SECONDARY)
accidental fall to floor (duration)..... yrs. mos. **3** ds. +

18. WHEN WAS DISEASE CONTRACTED **Accidental**
 IF NOT AT PLACE OF DEATH, **Unknown**

DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **Clinical**
 (Signed) **William T. Gaitler** M. D.

1/2, 19**28** (Address) **5300 Arsenal St.**

*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 **New Haven Mo.** DATE OF BURIAL **Jan. 4 1928**

20. UNDERTAKER **Peetz Bros. 3029 Lafayette Ave.** ADDRESS

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.

RECORD WITH UNFADING INK—THIS IS A PERMANENT RECORD

