

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

Do not use this space.

3662

1. PLACE OF DEATH

County.....
Towship.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No. **F 260**
Registered No. **1260**
St. Ward)

2. FULL NAME

(a) Residence. No. **7250 Lombard Pl.** St. **12** Ward. **University City Missouri**
(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 **M** 4. COLOR OF RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 2, 1857**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 9 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer) **Retired**
(c) Name of employer **Retired**

9. BIRTHPLACE (CITY OR TOWN) **Columbus Ohio**
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER **Loebel**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Unknown**
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER **Unknown**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Unknown**
(STATE OR COUNTRY)

14. INFORMANT **Miss Marie Bruchner**
(Address) **7250 Lombard Pl. University City**

15. FILED **6-19-29** **Xmas e Statistics**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **January 3 1929**

17. I HEREBY CERTIFY, That I attended deceased from **4/1/28**, 19, to **1/3/29**, 19, that I last saw him alive on **1/2/29**, 19, and that death occurred, on the date stated above, at **2:30** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis chronic
93c
(duration) **2** yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **93c**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **?**
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) **V.D. Park** M. D.
1/3/29, 19 (Address) **Resident 1849**

*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 **Calvary Cemetery** DATE OF BURIAL **1/2/29**

20. UNDERTAKER **Mullan Undertaking Co. 5165 Adm. St.** 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.

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