

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

Do not use this space.

20224

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City..... (No. **Christian Hospital**) St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_  
 Registered No. **5905**

**2. FULL NAME**

*Otto J. Braun*

(a) Residence No. **3702 N. Florissant** 9 Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **5** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>8-25-1912</i>				
7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, ..... hrs. or ..... min.
	<i>16</i>	<i>9</i>	<i>3</i>	

**8. OCCUPATION OF DECEASED**

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

**9. BIRTHPLACE (CITY OR TOWN)**

*Terria Ill*

(STATE OR COUNTRY)

**PARENTS**

10. NAME OF FATHER *Ernst Braun*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

*Germany*

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Louise Frederick*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

*Germany*

(STATE OR COUNTRY)

**14.**

INFORMANT *Ernst Braun*  
 (Address) *3702 N. Florissant*

**15.**

FILED **MAY 29 1929** *May 29 1929*  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 28 1929*  
 17. I HEREBY CERTIFY, That I attended *1915-29 3/28/29* and that I last saw him alive on *5/27/29*, 1929, and that death occurred, on the date stated above, at *9:10 p. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Acute Glomerular Nephritis*  
*cause unknown*

*130* (duration) yrs. *6* mos. ds.  
 CONTRIBUTORY (SECONDARY) *1/28* (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH *no* DATE OF.....

WAS THERE AN AUTOPSY *no*  
 WHAT TEST CONFIRMED *Clinical Symptom*  
 (Signed) *Chas P. Mott*, M. D.  
*5/28/29* (Address) *3903 Lee Ave*

\*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 *Terria Ill* DATE OF BURIAL *5/29 1929*

20. UNDERTAKER *H. C. Stockmud Co* ADDRESS *21176 Grand*

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

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.

10-0-2-261

