

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

Do not use this space.

2487

1. PLACE OF DEATH

County St. Louis
Township Kirkwood
City Kirkwood (No. _____)

Registration District No. 785
Primary Registration District No. 3037

File No. _____
Registered No. 25
St. _____ Ward _____

2. FULL NAME William Brinkmann

(a) Residence No. 314 W. Rose Hill St. _____ Ward Kirkwood 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 Widowed
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 1 - 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 1 9 6

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

9. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) do
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER do

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) do
(STATE OR COUNTRY)

14. INFORMANT August Brinkmann
(Address) Kirkwood Mo.

15. FILED 2/9 19 30 P. E. Barnes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1930 to Jan 7 1930 that I last saw him alive on Jan 6 1930 and that death occurred, on the date stated above, at 9 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Lobar Pneumonia
108

101111 (duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) arteriosclerosis

(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

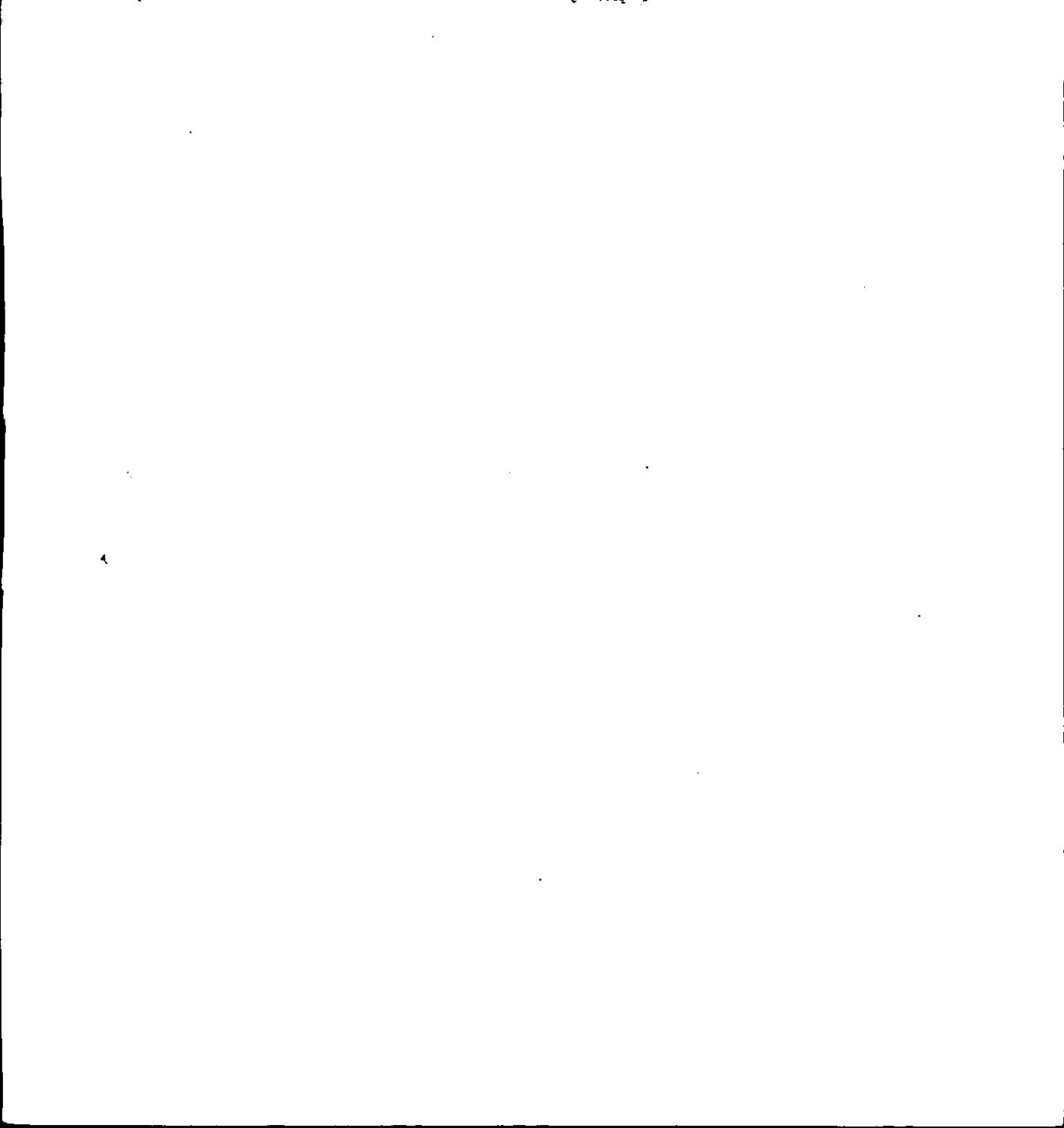
(Signed) E. Barnes M. D.

1/7, 1930 (Address) 209 World Kirkwood Mo

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 Dak Hill Cemtry DATE OF BURIAL 1/10/1930

20. UNDERTAKER Louis H Bopp ADDRESS Kirkwood Mo.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 785- File No. _____
 Township _____ Primary Registration District No. 3037 Registered No. 25-
 City Lirkwood (No. _____) St. _____ Ward _____

2. FULL NAME William Brinkmann
 (a) Residence, No. _____ St. _____ Ward _____ (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

MEDICAL CERTIFICATE OF DEATH

3. SEX m **4. COLOR OR RACE** w **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** wid
(write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 1930

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 1 - 1854

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS 75 MONTHS 9 DAYS 6
 If LESS than 1 day, _____ hrs. or _____ min.

_____ (duration) _____ yrs. _____ mos. _____ ds.

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

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

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

10. NAME OF FATHER _____
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER _____
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

Did an operation precede death? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____ (Signed) _____, M. D. _____, 19____ (Address) _____

14. INFORMANT _____ (Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ **DATE OF BURIAL** _____

15. FILED 3/9 30 C. E. Barnett **REGISTRAR**

20. UNDERTAKER _____ **ADDRESS** _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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