

**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**

1003

Township.....

Primary Registration District No.....

City **St. Louis** (No. **City 1003**)

File No. **10422**

10422

Registered No. **2104**

2104

St.

Ward)

2. FULL NAME

(a) Residence. No. **2665 Nebraska St.**, **17** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **38** yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male

White

Single

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

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

Nov 9 - 1891

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

38

3

16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).

unknown

(c) Name of employer

unknown

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Moore

10. NAME OF FATHER

Frank Brauner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Theresa Brande

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14. INFORMANT

(Address)

City 1003

15. FILED

19.....

Miss Carter

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

March 7 1930

17. I HEREBY CERTIFY, That I attended deceased from

Jan 12 1930 to March 7 1930
that I last saw him alive on *March 7 1930* and that death occurred, on the date stated above, at *5:15 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Pulmonary Tuberculosis
73% (fair advanced)*
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) *2* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

2665 Nebraska

19. DID AN OPERATION PRECEDE DEATH?

no

WAS THERE AN AUTOPSY?

no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

Ray Marguloi, M. D.

3/7 1930 (Address)

City 1003

*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

DATE OF BURIAL

National Cemetery

3-10 1930

20. UNDERTAKER

ADDRESS

Dr. C. Maydell

1926 Allen

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.

238
1
10

Gauner

1870

1871

1872

1873

1874

1875

1876

1877

1878

1879

1880

1881

1882

1883

1884