

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

Do not use this space.

25086

**1. PLACE OF DEATH**

County.....  
Township.....  
City *St. Louis*

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

File No.....  
Registered No. *7282*  
St..... Ward)

**2. FULL NAME**

*William J. Brinkman St. Louis Mo.*

(a) Residence. No. *4000 Kennedy Ave 11* 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**

3. SEX *male*  
4. COLOR OR RACE *white*  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *do*  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *unknown*  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min. *about 48 years*  
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. *General Laborer*  
(b) General nature of industry, business, or establishment in which employed (or employer) *St. Johns Hosp.*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Mo.*  
(STATE OR COUNTRY)

10. NAME OF FATHER *Fred Brinkman*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*  
12. MAIDEN NAME OF MOTHER *Annie Douthett*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *about know.*

14. INFORMANT *John Mc Grail*  
(Address) *3720 Cook Ave.*

15. FILED *JUL 21 1930*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 19, 1930*  
17. *No Physician in attendance*  
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.  
THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*9:30 Chronic Myocarditis*  
(duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) *100*  
(duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY? *ye*

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) *John J. Hurley* M.D.  
*7/21/30* (Address) *J. D. Gentry Coon*

\*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 *July 22 1930*

20. UNDERTAKER *Cullinane Bros* ADDRESS *1710 N. Grand*

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.

