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.

REC'D MAY 10 1939

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

791
1003

12117
Do not use this space.

3459

1. PLACE OF DEATH
(a) County ..... Registration District No. .....
(b) Township ..... Primary Registration District No. ..... Registered No. .....
(c) City St Louis - Mo. (d) Street No. 500 S. Kingsheghway St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 626 William Braker
(a) Residence, No. 4243 West Evans St. 11
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Child
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Child.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 11-13-30
7. AGE: YEARS 8 | MONTHS 5 | DAYS 0 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child
9. Industry or business in which work was done, as saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St Louis - Mo

FATHER
13. NAME: Wm. E. O
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri O

MOTHER
15. MAIDEN NAME: Josephine Jones
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Michigan

17. INFORMANT (ADDRESS): M. E. Matthews 500 S. Kingsheghway
18. BURIAL, CREMATION, OR REMOVAL
PLACE Mount Hope Cemetery DATE 4/15/39, 19
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Oscar J. Hoffmeister 4016 Chippewa Street
20. FILED APR 14 1939 J. F. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 4/13, 1939
22. I HEREBY CERTIFY, That I attended deceased from 7-28-38, 19..., to 4/13, 1939
I last saw him alive on 4/13 1939 Death is said to have occurred on the date stated above, at 3 45 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Rheumatic Fever	April 38
Rheumatic heart disease	" "

Other contributory causes of importance:

Name of operation none Date of —
What test confirmed diagnosis? — Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? — Date of injury —, 19...
Where did injury occur? —
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury —
Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) R. J. Blotters, M. D.
(Address) 500 S. Kingsheghway

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Edwin H. Leibinger

Licensed Embalmer No. 4049

P. O. Address 4016 Chippewa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.