

No. 2  
-2-43  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26516**

FILED AUG 18 1943

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7169**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Mo. Baptist Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether  
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **009**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **5152 Ridge Ave.**  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **Mathilda C. Bruegemann**  
(b) If veteran, name war (c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Aug.** day **8**  
year **1943** hour **11** minute **55 P.M.**

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married. **Divorced Widowed**  
6. (b) Name of husband or wife **Ernst H. Brueggemann**  
6. (c) Age of husband or wife if alive years

21. I hereby certify that I attended the deceased from **8/6-43** to **8/11-43**  
that I last saw him alive on **8/8-43**, 1943  
and that death occurred on the date and hour stated above.

7. Birth date of deceased **Oct. 7 1862**  
(Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day  
**80 10 1** hr. min.

Immediate cause of death  
**Myocardial infarction with  
ruptured chordae**  
Due to **hypertension**  
Due to

9. Birthplace **St. Charles Mo.**  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) **61**

10. Usual occupation **Housewife**  
11. Industry or business

Major findings:  
Of operations  
Of autopsy  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
12. Name **Unknown**  
13. Birthplace **Unknown** 9  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Unknown** 9  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Clara Werner**  
(b) Address **5152 Ridge Ave.**

17. (a) **Burial** (b) Date thereof **8-11-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Memorial Park Cem.**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director **Drehmann-Harral**  
(b) Address **1905 Union Blvd.**  
19. (a) **AUG 9 1943** **J. J. Budek**  
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury  
23. Signature **R. C. Coe DEAR** (M. D. or other)  
Address **4932 91st Land** Date signed **8-9-43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

4932  
1-4  
Margaret

**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.....

*Warren A. Carver*

Licensed Embalmer No.....

*3534*

P. O. Address.....

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

**If this body is not embalmed, fact should be so stated above.**