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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED AUG 8 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. **6543**

Registration District No. **318** Primary Registration District No. **1003**

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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town University City
(If outside city or town limits, write "RURAL")
 (d) Street No. 7524 Gannon Ave.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Effie W. Brasch
 (b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 25 year 1944 hour _____ minute 6 A.M.
 21. I hereby certify that I attended the deceased from May 1944 to July 25 1944
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
 (b) Name of husband or wife Leo Brasch (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: _____ (Month) (Day) (Year)

Immediate cause of death: Carcinoma of Cecum

8. AGE: Years about 64 Months -- Days -- If less than one day hr. _____ min. _____

Due to _____
 Due to _____
 Other conditions: Myocardial failure
(Include pregnancy within 3 months of death) Fibrillation

9. Birthplace Bohemia (City, town, or county) (State or foreign country)
 10. Usual occupation at home
 11. Industry or business _____
 12. Name Solomon Weil
 13. Birthplace Bohemia (City, town, or county) (State or foreign country)
 14. Maiden name Mary Brille
 15. Birthplace Bohemia (City, town, or county) (State or foreign country)

Major findings: Ca. of Cecum
 Of operations _____
 Of autopsy _____

MOTHER FATHER
 16. (a) Informant Mrs. Martha Grace
 (b) Address Forest Park Hotel
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-1944 (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Sinai Cemetery
 18. (a) Signature of funeral director Herman Rindshoff
 (b) Address 5216 Delmar Blvd.
 19. (a) JUL 25 1944 (Date received local registrar) (b) J. F. Budack (Registrar's signature)

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?
 While at work? _____ (Specify type of place) (e) Means of injury 0
 23. Signature J. H. P. Galster (M. D. or other) J. F. Budack
 Address _____ Date signed 7/25/44

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

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..... *H. P. Burgess*.....

Licensed Embalmer No. 4029.....

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.