

FILED NOV 1948
Registration District No. _____

Primary Registration District No. **1003**

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

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:
4548 Clarence ave
(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 Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4548 CLARENCE
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HERMANN HORSTBRINK

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MINNIE HORSTBRINK

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Jan 24 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 29
If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Furniture salesman

11. Industry or business retired

MOTHER FATHER { 12. Name Herman Horstbrink

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Obmeyer

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Minnie Horstbrink

(b) Address 4548 Clarence ave

17. (a) Burial (b) Date thereof Oct-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hiram Cemetery

18. (a) Signature of funeral director A. Kron L & U. Co.

(b) Address 2707 N. Grand Bl'vd

19. (a) OCT 24 1944 (b) J. Medick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 23
year 1944 hour 8 minute A M.

21. I hereby certify that I attended the deceased from 1941 19 Oct 23 19 44
that I last saw him alive on Oct 20 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocard Regurgitation

Due to _____

Due to 92

Other conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration ?

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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) (b) Means of injury

23. Signature Scott P. Smith (M. D. or nurse)

Address 4500 Clarence Date signed 10/23/44

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..... *V E Morris*

Licensed Embalmer No. *3360*

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.