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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 8 1944

Registration District No. 347

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38733

Primary Registration District No. 6076

Registrar's No. 2337

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robt. Koch Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1142 Days (Specify whether
In this community Same
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis 96

(c) City or town Florrisant
(If outside city or town limits, write "RURAL")

(d) Street No. R. R. #1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MARGARET BRUEGGEN

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife John Brueggen

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

7. Birth date of deceased August (Month) 17 (Day) 1902 (Year)

8. AGE: Years 42 Months 2 Days 25 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Henry Arkes
13. Birthplace Florrisant (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Theresa Henschel
15. Birthplace Bridgeton (City, town, or county) Mo. (State or foreign country)

16. (a) Informant John Brueggen
(b) Address Florrisant Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-44 (Month) (Day) (Year)
(c) Place: burial or cremation Sacred Heart Cem.

18. (a) Signature of funeral director Chas. F. Stuart
(b) Address 1225 Union Blvd.

19. (a) NOV 16 1944 (Date received local registrar) (b) E. G. McGavran (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 12 year 1944 hour 6 minute 00 A.M.

21. I hereby certify that I attended the deceased from Jan 3, 1944, 19..., to Nov 12, 1944 that I last saw her alive on Nov. 11, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Pulmonary Tuberculosis	5 yrs ?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

13 bl

Major findings:
Of operations
Of autopsy Pulmonary Tuberculosis

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Ira C. Layton (M. D. or other) M.D.
Address Robt. Koch Hosp. Date signed 11-12-44

Stuart

-102
-7-44

707

(Licensed Embalmer's Statement on Reverse Side)

DEC 8 1944

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.....

Licensed Embalmer No.....

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.