

S. No. 2
M-5-43
5-17-39
X36671

Registration District No. 218
FILED JAN 31 1945

Primary Registration District No. 1003

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

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:
Enroute To City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 (Specify whether
In this community... years, months or days)

3. (a) PRINT FULL NAME Johanna Brandenburger

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased November 7 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

<u>55</u>	<u>2</u>	<u>9</u>	hr. min.
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9. Birthplace Smithton Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Seamstress

11. Industry or business

12. Name Phillip Brandenburger

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

14. Maiden name Catherine Funk

15. Birthplace St. Clair Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mina Owings

(b) Address 4653a Maryland Ave.

17. (a) Removal (b) Date thereof 1-18-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Belleville, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JAN 17 1945 (b) J. F. Bredich
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 016

(d) Street No. 4653a Maryland Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 16
year 1945 hour 2:00 3 minute 31 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death

Bilateral Lobar
Pneumonia

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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? _____

23. Signature Albert H. Hoppe (Specify type of place) _____ (M. D. or other) 3
Address _____ Date signed 1/17/45

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..... *Albert G. Hopper*
Licensed Embalmer No. *2971*
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.