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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

1865

FILED MAR 14 1945
Registration District No. 318

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5460 Partridge Ave.
(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)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Bruce A. Unland

3. (b) If veteran, name war _____

3. (c) Social Security No. 489-22-1288

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct. 6, 1898
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>46</u>	<u>4</u>	<u>18</u>	hr. _____ min.

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

10. Usual occupation Shipping Clerk

11. Industry or business _____

MOTHER FATHER {

12. Name Frank Unland

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

14. Maiden name Mary Prentmann

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

16. (a) Informant Mary Unland

(b) Address 5460 Partridge Ave.

17. (a) Burial (b) Date thereof Feb. 28, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bromschwig Und. Co.

(b) Address 4746 West Florissant

19. (a) FEB 26 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 5460 Partridge 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 Feb day 24th
year 1945 hour 9:45 minute 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 _____

Due to Chronic tubercular cystitis

Due to Coronary of the heart

Other conditions _____
(include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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? _____ (c) Means of injury 3

23. Signature [Signature] (M. D. or other) _____

Address _____ Date signed 2/24/45

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.....

G. W. Wilkins

Licensed Embalmer No: *3575*

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.