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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. 18593

FILED JUN 30 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5208

**1. PLACE OF DEATH:**

(a) County

(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: St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether years, months or days)
In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County

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

(d) Street No. 1832 S. 11 Str.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME John Brynda

3. (b) If veteran, name war No

3. (c) Social Security No. 497-01-1406

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Emma Brynda

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Unknown about 1888
(Month) (Day) (Year)

8. AGE: Years About 57 Months Unknown Days If less than one day hr. min.

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

10. Usual occupation Hospital Attendent

11. Industry or business

MOTHER FATHER

12. Name August Brynda

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

14. Maiden name Philomina Krivan

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

16. (a) Informant August Brynda

(b) Address 604 Chestnut Str.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/15/45 (Month) (Day) (Year)

(c) Place: burial or cremation Old S.S. Peter & Paul

18. (a) Signature of funeral director Wm. C. Morgan

(b) Address 1926 Allen Ave.

19. (a) JUN 13 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 12th year 1945 hour 9:25 minute A. M.

21. I hereby certify that I attended the deceased from 6/5/45, 19, to 6/12/45, 19; that I last saw him alive on 6/12/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Some

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

Signature A. W. Gibinda (M. D. or other)

Address 1515 Lafayette 6/12/45 Date signed

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

(Licensed Embalmer's Statement on Reverse Side)

## 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 Benj. C. Duncan

Licensed Embalmer No. 2272

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.**