. S. No. 2
30M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 3 1945

State File No. 21723

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6415

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: 8823 NORTHCREST LANE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NONE (Specify whether

In this community 4 YR
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 8

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 8823 NORTHCREST LANE
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME LOUISE BRINK

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED 2

6. (b) Name of husband or wife William BRINK

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

7. Birth date of deceased DEC. (Month) 30 (Day) 1858 (Year)

8. AGE: Years 86 Months 6 Days 22 If less than one day hr. min.

9. Birthplace GERMANY (City, town, or county) 4 (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name FRED HANKEY
13. Birthplace GERMANY (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name UN KNOWN
15. Birthplace GERMANY (City, town, or county) 4 (State or foreign country)

16. (a) Informant Oscar Brink
(b) Address 1816 Laffingwell Blvd.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof July 25-1945 (Month) (Day) (Year)
(c) Place of burial or cremation Hoffman Sta TRINITY LUTH CEM.

18. (a) Signature of funeral director DIEDRICH F. HOME
(b) Address 8318 HALLS FERRY RD.

19. (a) JUL 24 1945 (Date received local registrar) (b) J. F. Brebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22 year 1945 hour 11 15 minute A M.

21. I hereby certify that I attended the deceased from Jan 1945 to July 22 1945 that I last saw h alive on July 21 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cardio renal vascular disease — Duration years

Due to

Due to

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? (e) Means of injury 0

23. Signature W. P. Hamilton (M. D. or other) MD

Address 8363 Halls Ferry Date signed July 23 45

(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.....

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.