

DEPARTMENT OF COMMERCE
BUREAU OF CONSULS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27337

State File No. _____

Registration District No. 117

Primary Registration District No. 5436

Registrar's No. _____

1. PLACE OF DEATH:

(a) County GASCONADE
(b) City or town BAY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 22 YEARS

3. (a) PRINT FULL NAME CHARLOTTE WILHEMINA ENGELBRECHT

3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife JOSEPH ENGELBRECHT 6. (c) Age of husband or wife if alive DEAD years
7. Birth date of deceased FEBRUARY 13 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 5 24 hr. min.

9. Birthplace SWISS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business _____

12. Name JOHN DIEDRICH BRINK
13. Birthplace ALTENA GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name FREDERIQUE MEIER
15. Birthplace SWISS MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant PAUL ENGELBRECHT
(b) Address OWENSVILLE, MO.

17. (a) BURIAL (b) Date thereof AUG 10 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BAY ZION'S CEMETERY

18. (a) Signature of funeral director Millard H. N. Winter
(b) Address Owensville Mo.

19. (a) 8-9-45 (b) Mrs. J. B. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GASCONADE
(c) City or town BAY
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 7
year 1945 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from Jan 1945 to Aug 7 1945
that I last saw him alive on Aug 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 12 days
Due to Arterial Sclerosis & Hypertension
Due to _____

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

Major findings: Of operations _____ Of autopsy g42
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 _____

23. Signature Charles L. Schmidt M.D. or other _____
Address Owensville Mo. Date signed 8-9-45

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 9-6-45

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 Mc

....., Registered Apprentice No.....
working under my personal supervision.

Signed McClintock Winter

Licensed Embalmer No. 3838

P. O. Address Doverville, Va.

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.