V. S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

37171

FILED NOV 30 1945

Registration District No. 128

Primary Registration District No. ~~2000~~ 5465

State File No.

Registrar's No. 909

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Rural, N Camden ~~Springfield~~ Twp (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Man died at edge of town, Highway #66 Dead on arrival at St. John's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County ST. LOUIS

(c) City or town CASTLE WOOD (If outside city or town limits, write "RURAL")

(d) Street No. — (If rural, give location)

(e) Citizen of foreign country? NO. 1 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME WILLIAM BREIT

3. (b) If veteran, name war UNK.

3. (c) Social Security No. UNK.

4. Sex MALE

5. Color or race White

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

6. (b) Name of husband or wife LEODA BREIT

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased JUNE (Month) 10, (Day) 1899 (Year)

8. AGE: Years 46 Months 4 Days 26 If less than one day hr. min.

9. Birthplace ST. LOUIS, (City, town, or county) MO. (State or foreign country)

10. Usual occupation STOREKEEPER

11. Industry or business RESORT

FATHER
12. Name MATTHEW BREIT
13. Birthplace unknown (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name EMMA REITER
15. Birthplace unknown (City, town, or county) Germany (State or foreign country)

16. (a) Informant Mrs. Leoda Breit

(b) Address Castlewood, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/6/45 (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director Hoppe Funeral Service

(b) Address St. Louis, Mo.

19. (a) 11-6-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 6 year 1945 hour 3 minute 20 P M.

21. I hereby certify that I attended the deceased from Oct. 21, 1945, to NOV. 6, 1945; that I last saw him alive on NOV. 6, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Spontaneous pneumothorax	2 wks.
Due to Tuberculosis of lungs	
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

23. Signature Wm W. Carter M.D. (Dr or other)

Address 603 Brentwood, Clayton, Mo. Date signed 11-6-45

944

(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.....

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.