

S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 5 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42536

State File No. _____
Registrar's No. **2956**

Registration District No. **317** Primary Registration District No. **3069**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Richmond Heights**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Mary's Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 weeks**
(Specify whether In this community _____ years, months or days)

3. (a) PRINT FULL NAME **August J. Von Brunn**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **Feb. 8, 1871**
(Month) (Day) (Year)

8. AGE: Years **74** Months **10** Days **15** If less than one day _____ hr. _____ min.

9. Birthplace **New York City**
(City, town, or county) (State or foreign country)

10. Usual occupation **Priest**

11. Industry or business _____

12. Name **Anton Von Brunn**

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

14. Maiden name **Elizabeth Gelssier**

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

16. (a) Informant **Frank Overman**

(b) Address **4718 Farlin Ave.**

17. (a) **Burial** (b) Date thereof **Dec. 27, 45**
(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) **12-29-45** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Madison**

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

(d) Street No. **4330 Shreve Ave.**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **23** year **1945** hour **12** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Oct 2** 19**45** to **Dec 23** 19**45** that I last saw him alive on **Dec 22** 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary Thrombosis** Duration **1 day**

Due to **Prostatic Hypertrophy** ?

Due to **94a**

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

Major findings: **Prostatic Hypertrophy** **PHYSICIAN**
Of operations _____
Of autopsy _____
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 **[Signature]** M.D. or other _____
Address **966 Cass St. St. Louis** Date signed **12/26/45**

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

76
8
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JAN 23 1945

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 W. Wilkinson

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.