

S. No. 2
M-5-43
7-5-17-39
I X36871

State File No.

FILED 8182

Registration District No.

Primary Registration District No. **1003**

Registrar's No. **6146**

1. PLACE OF DEATH:

(a) County.....

(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
De Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **12 days** Specify whether

In this community **life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County..... **96**

(c) City or town **Ferguson** **6**
(If outside city or town limits, write "RURAL") **NR 2**

(d) Street No. **424 Harrison**
(If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No) **1**
If yes, name country.....

3. (a) PRINT FULL NAME **Peter Nielsen Braroe**

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

3. (c) Social Security No.....

4. Sex **M.** 5. Color or race **W.**

6. (a) Single, widowed, married, divorced **M.**

6. (b) Name of husband or wife **Jeanne E. Sterbenz**

6. (c) Age of husband or wife if alive **34** years

7. Birth date of deceased **Jan. 4 1910**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

36 6 5 hr. **2** min.

9. Birthplace **Webster Groves, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Ry. Mail Clerk**

11. Industry or business **United States Gov't.**

MOTHER FATHER { 12. Name **Peter Nissen Braroe**

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

14. Maiden name **Mary Winther**

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

16. (a) Informant **Mrs. Jeanne Braroe**

(b) Address **424 Harrison, Ferguson, Mo.**

17. (a) **burial** (b) Date thereof **7/12-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cemetery**

18. (a) Signature of funeral director **Alexander Jones, Inc.**

(b) Address **6175 Delmar**

19. (a) **JUL 12 1946** (Date of local registration)
J. F. Brebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July 9** day
year **1946** hour **8:** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **July 2, 1946** to **July 9, 1946**
that I last saw him alive on **July 9, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death:
Cerebral Hemorrhage
due to Stenosis - hypertens + hypercholesterolemia

Duration **4 days**

Other conditions (Include pregnancy within 3 months of death)
85

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?

While at work? (Specify type of place) Means of injury

23. Signature **J. F. Brebeck** (M. D. or other)
Address **401 Humboldt Bldg** Date signed **7/11/46**

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

Dr. D B Flavin
Humbolt Bldg -
1-4-

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.....

Jos. E. McCulloch

Licensed Embalmer No. *2460*

P. O. Address *6175 Delmar*

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.