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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 25 1946
318

1003

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 9795

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: City Sanitarium

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 1/2 yrs. Mos. 28 ds.
(Specify whether _____)

In this community 29 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 5400 Arsenal St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHARLOTTE BRUCHMAN

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16
year 1946 hour 11.50 minute P M.

21. I hereby certify that I attended the deceased from Apr. 1,
1st to 41 Nov. 16, 1946

that I last saw her alive on Nov. 16, 1946
and that death occurred on the date and hour stated above.

4. Sex female / 5/ Color or race white

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

6. (b) Name of husband or wife Robert Bruchman

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

7. Birth date of deceased July 23 1988
(Month) (Day) (Year)

Immediate cause of death _____

Broncho Pneumonia 15 @

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>3</u>	<u>23</u>	hr. _____ min.

Due to _____

Decubitus Ulcer 7 ds.

9. Birthplace not given California
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

107

11. Industry or business _____

12. Name unknown

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace not given Cal.
(City, town, or county) (State or foreign country)

Major findings: _____

Of operations: _____

Of autopsy: _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Clara Robinson

(b) Address 5400 Arsenal St.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) BURIAL (b) Date thereof 11/18/1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. OLIVE HEBREW BERGER MEMORIAL

(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? _____

18. (a) Signature of funeral director BERGER MEMORIAL

(b) Address 4715 N. PHERSON AVE.

19. (a) NOV 18 1946 (b) J. F. Bredack
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature R. Hoffstaller (M. D. or other) M.D.
Address _____ Date signed _____

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 *Claris A. Gudberg*
Licensed Embalmer No. 4229

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.