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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 25 1946
Registration District No. **318**

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

State File No. **38432**
Registrar's No. **9732**

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4641 Greer Ave. /
(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)

3. (a) PRINT FULL NAME **Sarah Brutsche**
3. (b) If veteran, name war.....
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **August Brutsche**
6. (c) Age of husband or wife if alive **81** years
7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 75 hr. min.

9. Birthplace **Greenwood Mississippi**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife.**

11. Industry or business.....

MOTHER FATHER {
12. Name **(?) Taylor**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace **"**
(City, town, or county) (State or foreign country)

16. (a) Informant **August Brutsche**
(b) Address **4641 Greer Ave.**

17. (a) **Burial** (b) Date thereof **11/16/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**
18. (a) Signature of funeral director **Stroot-Carroll**
4600 Natural Bridge Ave.
(b) Address

19. (a) **NOV 15 1946** (b) **J. F. Brutsche**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4641 Greer Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **14**
year **1946** hour **7** minute **15** A. M.
21. I hereby certify that I attended the deceased from.....
19..... to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Coronary Thrombosis
Due to.....
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:
(c) 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) (c) Means of injury.....
23. Signature **Thomas J. Callahan** (M.D. or other)
Address..... Date signed **11-17-46**

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 *Albert Mayfield*
Licensed Embalmer No. *3077*
P. O. Address *St Louis Mo*

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.