

No. 2
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5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10598**
Registrar's No. **3257**

FILED APR 14 1948

Registration District No. **398** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3322a Halliday 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 Pauline Brogli
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 8, 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 9 17 hr. _____ min. _____

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER

12. Name August Fritsche

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

14. Maiden name Don't Know

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

16. (a) Informant Eleanor Strunk

(b) Address 3322a Halliday Ave.

17. (a) Burial (b) Date thereof 3-28-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Weick Bro. Und. Co.

(b) Address 2201 S. Grand Bl.

19. (a) MAR 27 1947 (b) _____
(Date received local registrar) (Registrar's signature)

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. 3322a Halliday Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25,
year 1947 hour 3 minut 15 P.M.
21. I hereby certify that I attended the deceased from 3/17/47
to 3/25/47, 1947,
that I last saw her alive on 3/20/47, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Duration _____
Due to _____
Due to _____
Other conditions Diaper non toxic
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____
Of autopsy rupture
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 Albert Strunk M.D. (M. D. or other) _____
Address 3109 S. Grand Date signed 3/25/47

Griot & Sons Inc.

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.....

James R. Dunn

, Registered Apprentice No. 403

working under my personal supervision.

Signed

[Handwritten Signature]

Licensed Embalmer No. 3722

P. O. Address 2201 S. Grand Bl.

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.