

No. 2
12-45
5-17-39
I X 67070

FILED JUN 9 1947

State File No.

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 93

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
404 McDonough Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life time
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 404 McDonough
(If rural, give location) _____
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Henry J. Broeker

3. (b) If veteran, name war NIL

3. (c) Social Security No. 496-14-8199

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Martha V. (Radell) Broeker
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased April 19 1875
(Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days 10
If less than one day _____ hr. _____ min.

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

10. Usual occupation Painting & Decorating

11. Industry or business

MOTHER FATHER
12. Name Henry Broeker
13. Birthplace Westphalia Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mary Mueller
15. Birthplace St. Charles Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Henry J. Broeker

(b) Address 404 McDonough-St. Charles, Mo.

17. (a) burial (b) Date thereof May 31-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cem

18. (a) Signature of funeral director H. D. Dallmeyer & Sons Co

(b) Address 800 N. 2nd-St. Charles, Mo.

19. (a) June 2 47 (b) Frankie Hewitson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1947 hour 5:45 minute _____ A.M.

21. I hereby certify that I attended the deceased from Dec 12, 1945 to May, 1947;
that I last saw him alive on May 28, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death, _____
Myocardial failure, arterio
sclerotic heart disease
Due to generalized arteriosclerosis
hypertension
Due to _____

Other conditions Fracture right
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Vernon G. Labadie (M.D. or other) MD
Address St. Charles, Mo. Date signed 5/31/47

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

Date Filed JUN 27 1947
District File Number

District Health Officer No. 9,
RECEIVED

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..... *Joseph F. Landolt*
Licensed Embalmer No. 4189
P. O. Address..... St. Charles

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistration District No. 310Primary Registration District No. 3058Registrar's No. 93

1. PLACE OF DEATH:

- (a) County St Charles
 (b) City or town St Charles
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(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 NAMEHenry J. Brooks

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.

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

7. Birth date of deceased.
- April 19
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
-
- 72
- hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
- MO

10. Usual occupation.

11. Industry or business

- MOTHER FATHER { 12. Name
 { 13. Birthplace (City, town, or county) (State or foreign country)
 { 14. Maiden name
 { 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
 (b) Address
 17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

13. (a) Signature of funeral director. (b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State. (b) County.
 (c) City or town. (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- May
- 29
-
- year
- 1947
- hour minute M.

21. I hereby certify that I attended the deceased from 12 to 19 1947
 that I last saw him alive on May 28, 1947
 and that death occurred on the date and hour stated above.
 Immediate cause of death.

Duration

- Due to 186 A
 Due to 18
 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:

- (a) Accident, suicide, or homicide (specify) Accident ✓
 (b) Date of occurrence May 28 - 1947
 (c) Where did injury occur? St Charles, St Charles MO
 (City or town) (County) (State)
at home
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? no (Specify type of place)
 (e) Means of injury Fall

23. Signature V. A. Schreiner (M. D. or other) MD
 Address St Charles, Mo Date signed 6/1/47

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

18480