

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 9 1947

Registration District No. 117

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5436

State File No. B3877

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Rural Boulevard Twp.
(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 Lifetime
years, months or days)

3. (a) PRINT
FULL NAME

Odessa Amanda Brinkmann

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 Single

6. (b) Name of husband or wife.

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

7. Birth date of deceased March 19,
(Month) (Day) (Year)

8. AGE:

Years
51

Months
4

Days
11

If less than one day

hr. min.

9. Birthplace:

Bay
(City, town, or county)

Missouri
(State or foreign country)

10. Usual occupation:

Housework

11. Industry or business:

12. Name Frederick Wm. Brinkmann
13. Birthplace Bay Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Louise Schulte
15. Birthplace Bay Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant F. Wm. Brinkmann

(b) Address Bay, Missouri

17. (a) Burial (b) Date thereof 8 1 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zoar M. E. Drake, Mo.

18. (a) Signature of funeral director Milford H. H. Winter

(b) Address Owensville, Mo.

19. (a) 8/1/47 (b) Odessa Brinkmann
(Date) (Signature of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
year 47 hour 13 minute A M.

21. I hereby certify that I attended the deceased from
July 28 1947 to July 30 1947
that I last saw her alive on July 28 1947
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Hemorrhage
Duration 4 days

Due to Hypertension
Due to Diabetes Mellitus

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

Major findings:
Of operations 61
Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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? 0

(Specify type of injury)
While at work? _____
(a) Means of injury _____

23. Signature Charles A. Schuch (M. D. or other)
Address Bay, Mo. Date signed 8-1-47

RECEIVED
District Health Officer No. 9,
District File Number
8-8-47
Date Filed

NOV 4 1948

APR 21 1953

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Wesley N. H. Winder
Licensed Embalmer No. 3838
P. O. Address Owensville 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.