S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 262770

FILED AUG 13 1947

Registration District No. 3 1 Primary Registration District No. 3069 Registrar's No. 1591

96
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis 96
(c) City or town Rock Hill 14
(If outside city or town limits, write "RURAL")
(d) Street No. 921 Tavalon 0
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 1
If yes, name country .....

3. (a) PRINT FULL NAME August Brockman
3. (b) If veteran, name war .....
3. (c) Social Security No. 493-05-2462
4. Sex male 0
5. Color or race white
6. (a) Single, widowed, married, divorced married 1
6. (b) Name of husband or wife Carrie nee Koch
6. (c) Age of ~~husband or~~ wife if alive 59 years
7. Birth date of deceased Oct. (Month) 10 (Day) 1877 (Year)

8. AGE:

Years	Months	Days	If less than one day
69	9	12	..... hr. ..... min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Co. Gas Co. Leak Dept.
11. Industry or business .....

FATHER
12. Name Everhardt Brockman
13. Birthplace Germany (City, town, or county) (State or foreign country) 4

MOTHER
14. Maiden name Wilhemina Peters
15. Birthplace Germany (City, town, or county) (State or foreign country) 4

16. (a) Informant Carrie Brockman
(b) Address 921 Tavalon, Rock Hill
17. (a) cremation (Burial, cremation, or removal) (b) Date thereof July 25, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Chapel of Memories
18. (a) Signature of funeral director Jay B. Smith
(b) Address 7456 Manchester Ave.
19. (a) 7-26-47 (Date received local registrar) (b) Cecil A. Shay MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22
year 1947 hour 12:15 minute P M.
21. I hereby certify that I attended the deceased from June 1, 1946, to July 22, 1947; that I last saw him alive on July 22, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis Chr	10 yr
Due to Nephritis Chr.	
Due to Arteriosclerosis Gen	
Other conditions (Include pregnancy within 3 months of death)	

131 N

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause of 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? ..... (Specify type of place)
While at work? ..... (e) Means of injury 0
23. Signature Carl C. Dunton (M. D. or other) MD
Address 227 E Lockwood Webster Grove Date signed 7-23-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

AUG 1 1947

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. J. H. Burgess

Licensed Embalmer No. 4029

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.