No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28872

FILED SEP 2 1947 #73290

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7827

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(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 000

(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 5242 Beacon 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JOHN ~~BRASCH~~ William Braasch

3. (b) If veteran, name war NONE

3. (c) Social Security No.

4. Sex MALE

5. Color or race W

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CAROLINE BRAASCH

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased MARCH (Month) 6 (Day) 1877 (Year)

8. AGE: Years 70 Months 5 Days 10 If less than one day hr. min.

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

10. Usual occupation BUTCHER

11. Industry or business MUEHLING PACKING CO

FATHER
12. Name CHRISTOPHER BRAASCH
13. Birthplace (City, town, or county) GERMANY (State or foreign country)

MOTHER
14. Maiden name NOT KNOWN
15. Birthplace (City, town, or county) " " (State or foreign country)

16. (a) Informant MRS. CARRIE BRAASCH
(b) Address 5242 BEACON AVE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation VALHALLA CEMETERY

18. (a) Signature of funeral director Calvin F. Fautz Funeral Ho
(b) Address 4828 NAT'L BRIDGE BLD

AUG 18 1947

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 16th year 1947 hour 7:35 minute A M.

21. I hereby certify that I attended the deceased from 7/1/47, 19, to 8/16/47, 19; that I last saw him alive on 8/16/47, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Failure

Due to Diabetic acidosis

Due to Hypertensive Cardio-Vascular Disease

Other conditions Psychosis associated with Cerebral Thrombosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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

23. Signature 1515 Lafayette (M.D.) 8/16/47
Address Date signed

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

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.....

Licensed Embalmer No.....

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.