

No. 2  
-1/47  
5-17-39

FILED SEP 29 1947

Registration District No.                     

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jefferson Barracks  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Veterans Administration Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months and 25 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 36

(c) City or town Route #1, Union  
(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                     

3. (a) PRINT FULL NAME BRUNE, Ben T.

3. (b) If veteran, name war WW-1

3. (c) Social Security No. 487143628

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 11  
year 1947 hour 9:50 minute A M.

4. Sex M 5. Color or race White

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

6. (b) Name of husband or wife                     

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

7. Birth date of deceased March 16, 1886  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 16, 1947 to Sept. 11, 1947  
that I last saw him alive on Sept. 11, 1947  
and that death occurred on the date and hour stated above.

Duration                     

Immediate cause of death Cirrhosis of liver

Due to                     

Due to                     

Other conditions                       
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

61	5	25	br. min
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9. Birthplace Franklin Co., Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Odd jobs

11. Industry or business                     

12. Name Unknown John Jacob Brune

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

14. Maiden name Unknown Johanna Brune

15. Birthplace Unknown Frankfurt, Ger  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations                     

Of autopsy No autopsy

PHYSICIAN                       
Underline the cause of which death should be charged statistically.

16. (a) Informant Registrar, Vet. Adm. Hosp. Jefferson Barracks, Mo.

(b) Address                     

17. (a) Burial (b) Date thereof 9-13-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union, Missouri

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

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                     

18. (a) Signature of funeral director Alman Funeral Home

(b) Address Union, Mo.

19. (a) 9-13-47 (b)                       
(Date received local registrar) (Registrar's signature)

23. Signature L. E. Stilwell (M. D. or other)                     

Address                      Date signed 9/11/47

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

MOTHER FATHER

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 E. A. Olmann

Licensed Embalmer No. 1686

P. O. Address Union 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.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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: *St. Louis Hosp.*  
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County \_\_\_\_\_

(c) City or town *St. Louis*  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME *Brune Ben J*

3. (b) If veteran, name war *WW #1* 3. (c) Social Security No. *487143628*

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *S*

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

7. Birth date of deceased *3-16-1886*  
(Month) (Day) (Year)

20. DATE OF DEATH Month *9* day *11* year *1950* hour *5:00* minute \_\_\_\_\_

21. I hereby certify that I attended the deceased from *9-16-50* to *9-11-50* 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

8. AGE: Years *61* Months *5* Days *25* If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace *Franklin, Mo.*  
(City, town, or county) (State or foreign country)

10. Usual occupation *Gen. Contractor*

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name *John Jacob Brune*

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

14. Maiden name *Theresa Brechtman*

15. Birthplace *Franklin, Mo.*  
(City, town, or county) (State or foreign country)

16. (a) Informant *Joe Brune*

(b) Address *Union Mo.*

17. (a) \_\_\_\_\_ (b) Date thereof *9/13/1947*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) *9-12-50* (b) *Paul C. Blain*  
(Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (e) Means of injury

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

COPY TO SUPPLEMENTARY

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

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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