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DM-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3607**

FILED FEB 16 1948

Registration District No. **517**

Primary Registration District No. **4469**

Registrar's No. **4**

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

1. PLACE OF DEATH:

(a) County STE. GENEVIEVE

(b) City or town STE. GENEVIEVE
(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 LIFE years, months or days)

2. USUAL RESIDENCE OF DECEASED: **95**

(a) State MISSOURI (b) County STE. GENEVIEVE

(c) City or town STE. GENEVIEVE **1**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) **1**

(e) Citizen of foreign country? NO (Yes or No) **0**

If yes, name country _____

3. (a) PRINT FULL NAME BLANCH BRECKLE

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 17
year 1948 hour 12:00 minute 12 A.M.

21. I hereby certify that I attended the deceased from Aug. 10
1945, to Jan. 17 1948

that I last saw h. ER alive on Jan. 16 1948
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife AUGUST BRECKLE 6. (c) Age of husband or wife if
alive 65 years

7. Birth date of deceased AUG. 14 1881
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration 1/10/48

Due to General Arteriosclerosis ?
Chr. myocarditis

Due to Chr. Nephritis

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

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

66 5 3 hr. _____ min.

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy 12/13

Underline the cause to which death should be charged statistically.

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name JAMES W. KENNARD

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

14. Maiden name MARIE KEMPE

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

16. (a) Informant August Breckle

(b) Address Ste. Genevieve Mo

17. (a) Burial (b) Date thereof 1-19-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ste. Genevieve Mo

18. (a) Signature of funeral director Spec. Basher

(b) Address Ste. Genevieve Mo

19. (a) 1-26-48 (b) Genevieve M. Karl
(Date received local registrar) (Registrator's signature)

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 0

23. Signature Dr. Lanning (M. D. or other) _____
Address Ste. Genevieve Mo Date signed 1/17/48

District Health Officer No. 4
District File Number 248-143
Date Filed 2-11-48

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 *Les C. Baskin*

Licensed Embalmer No. 1985

P. O. Address *Sto. Genevieve 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.