.S. No. 300
EV. 10.48

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

FILED MAR 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10205

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2652

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2441 S. 3rd St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 23 – 2441 S. 3rd St. 2 4 0

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle):
c. (Last): Brazier

4. DATE OF DEATH (Month) (Day) (Year): 3/19/50

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow W
8. DATE OF BIRTH: Dec. 29, 1871
9. AGE (In years last birthday): 78 — If under 1 year: Months: Days: If under 24 hrs.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): England 4
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Albert
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Harry Romberg--6811a S. Broadway

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Cholangitis

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): none
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): none
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/18, 1950, *to* 3/19, 1950, *that I last saw the deceased alive on* 3/18, 1950, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Conger MD
23b. ADDRESS: 2105 So Broadway
23c. DATE SIGNED: 3/20/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3/22/50
24c. NAME OF CEMETERY OR CREMATORY: St. Matthews Cem.
24d. LOCATION (City, town, or county) (State): St. Louis, Missouri

DATE REC'D BY LOCAL REG.: MAR 20 1950
REGISTRAR'S SIGNATURE: J B Bassler
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wacker-Feldele 3634 Gravois

(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.....

.....

working under my personal supervision.

Student Embalmer No.....

Signed Frank J. Thyland Sr.

Signed.....
Student Embalmer

Licensed Embalmer No. 2645

P. O. Address St Louis 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.