

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21410

FILED JUL 5 1950

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5515**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo 2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros Hospital		d. STREET ADDRESS (If rural, give location) 3416 Winnebago Street	
3. NAME OF DECEASED (Type or Print) a. (First) William		b. (Middle) Brynda (Brinda)	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) June 24 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 29 1885
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) St Louis Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Joseph Brynda	
13b. MOTHER'S MAIDEN NAME Mary Bosek		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 494-10-7383	
17. INFORMANT'S SIGNATURE OR NAME Frances Brynda		ADDRESS 3416 Winnebago	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) congestive Heart Failure 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. Diabetes Mellitus	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 434A			
22. I hereby certify that I attended the deceased from July 1945 , to June 1950 , that I last saw the deceased alive on 24 June, 1950 , and that death occurred at 11:50 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) M. G. Mulhally, M.D.		23b. ADDRESS 3804 N. Wilmington	
23c. DATE SIGNED 6-26-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/27/50	
24c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery		24d. LOCATION (City, town, or county) (State) St Louis Mo	
DATE REC'D. BY LOCAL REG. JUN 26 1950		25. FUNERAL DIRECTOR'S SIGNATURE Wendell L. ... ADDRESS 1926 Allen Av	

(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 me

working under my personal supervision.

Student Embalmer No.

Signed Dale A. Strawn

Signed.....
Student Embalmer

Licensed Embalmer No. 4533

P. O. Address 1956 Allen

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.