

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

#114,193

318

1003

7084

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.				d. STREET ADDRESS (If rural, give location) 3815 CONNECTICUT			
3. NAME OF DECEASED (Type or Print)		a. (First) ELIZABETH		b. (Middle) BRANDCASSE		c. (Last) BRANDCASSE	
4. DATE OF DEATH (Month) (Day) (Year) August 19th, 1950		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH MARCH 6, 1879		9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		11. BIRTHPLACE (State or foreign country) ILLINOIS	
12. CITIZENRY OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME JOHN GEORGE		13b. MOTHER'S MAIDEN NAME PROPST		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOSEPHINE SCHILL 3815 CONNECTICUT			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Thrombosis right middle cerebral artery.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (m.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 332X				22. I hereby certify that I attended the deceased from <u>8/18/50</u> , 19 <u>50</u> , to <u>8/19/50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>8/19/50</u> , 19 <u>50</u> , and that death occurred at <u>5:40pm</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>John W. Koehler, M.D.</u>		23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 8/21/50			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Aug. 22, 1950		24c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCELS		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.	
DATE REC'D BY LOCAL REG. AUG 21 1950		REGISTRAR'S SIGNATURE <u>J. B. Savater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kate Guard Hall, Inc</u>		ADDRESS <u>206 Duval</u>	

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

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.....

James C. Hill

Signed.....
Student Embalmer

Licensed Embalmer No.....

4347

P. O. Address.....

2906 Pearl

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.