

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

29270

State File No.

AUG 23 1952

 BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7474**

1. PLACE OF DEATH a. COUNTY 0			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY 2152		
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		d. STREET ADDRESS (If rural, give location) 5412 Michigan Ave.
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY HOSP. #1			d. STREET ADDRESS (If rural, give location) 15 5412 Michigan Ave.		
3. NAME OF DECEASED (Type or Print) a. (First) Joseph		b. (Middle) BRINKMANN	c. (Last) BRINKMANN	4. DATE OF DEATH (Month) (Day) (Year) AUG-3-52	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH AUG-4-1878	9. AGE (In years last birthday) 73 YRS	F UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) PROOF Reader		10b. KIND OF BUSINESS OR INDUSTRY CHASE BAg. Co	11. BIRTH PLACE (State or foreign country) ST. LOUIS MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME JOSEPH BRINKMANN		13b. MOTHER'S MAIDEN NAME MARY WIDEMAN		14. NAME OF HUSBAND OR WIFE ADDIE Brinkmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Addie Brinkmann 5412 Michigan		
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) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Cerebral Apoplexy					INTERVAL BETWEEN ONSET AND DEATH
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.					
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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 334X		
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 900 P. m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Carl Smith		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 8/6/52	
24a. BURIAL OR REMOVAL (Specify)	24b. DATE AUG-7-52	24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo		
DATE RECD BY OFFICE AUG 6 1952		REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schurer 3125 Lafayette Ave		

(Licensed Embalmer's Statement on Reverse Side)

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Joseph Dollmer

Licensed Embalmer No. 41014

P. O. Address 3125 Lafayette

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.