

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 2905
0525

FILED JAN 28 1953

BIRTH NO. 4328 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

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) St. Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis Mo 2167	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hosp		d. STREET ADDRESS (If rural, give location) 16 3731 ^S Compton	
3. NAME OF DECEASED (Type or Print) a. (First) Gary b. (Middle) c. (Last) Bruncker		4. DATE OF DEATH (Month) (Day) (Year) 1 16 53	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 1-15-53
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Clifford Bruncker	
13b. MOTHER'S MAIDEN NAME Joyce Jordan		14. NAME OF HUSBAND OR WIFE None	
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 Clifford Bruncker		ADDRESS 3731 ^S Compton	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature Birth (31 wks)</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> ANTECEDENT CAUSES Morbidity 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input 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? 776x		22. I hereby certify that I attended the deceased from <u>1-15, 1953</u> to <u>1-16, 1953</u> , that I last saw the deceased alive on <u>1-16, 1953</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>W. R. Baum M.D.</u> (Degree or title)		23b. ADDRESS <u>3227 S. Broadway</u>	
23c. DATE SIGNED <u>1-17-53</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	
24b. DATE 1-17-53		24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	
24d. LOCATION (City, town, or county) (State) St. Louis Mo		25. FUNERAL DIRECTOR'S SIGNATURE <u>Moylell Funeral Home</u>	
DATE REC'D BY LOCAL REG. JAN 17 1953		ADDRESS 1926 Allen	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

NOT EMBALMED

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Isabel A. Kreuman

Licensed Embalmer No. _____

P. O. Address _____

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.