

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 10 1953

BIRTH NO. _____ REG. DIST. NO. **322** PRIMARY REG. DIST. NO. **3071** Registrar's No. **17**

1. PLACE OF DEATH
a. COUNTY **Saline**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE **Mo** b. COUNTY **Saline**

b. CITY (If outside corporate limits, write RURAL and give township) **Slater** c. LENGTH OF STAY (in this place) **60 days** c. CITY OR TOWN **Slater** d. Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **131 North Main St** e. STREET ADDRESS (If rural, give location) **506 North Main St**

3. NAME OF DECEASED
a. (First) **Martin** b. (Middle) **Antoine** c. (Last) **BREMER** **4. DATE OF DEATH** (Month) (Day) (Year) **May-31-1943**

5. SEX **Male** **6. COLOR OR RACE** **White** **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)** **married** **8. DATE OF BIRTH** **Nov 23-1871** **9. AGE** (In years) **71-6-8** **10a. USUAL OCCUPATION** (Give kind of work done during most of working life even if retired) **Retired farmer** **10b. KIND OF BUSINESS OR INDUSTRY** **retired** **11. BIRTHPLACE** (City and State) **Starkenburg, Mo** **12. CITIZEN OF WHAT COUNTRY?** **US**

13a. FATHER'S NAME **Henry Bremer** **13b. MOTHER'S MAIDEN NAME** **Sara Verholdt** **14. NAME OF HUSBAND OR WIFE** **Clara Bremer**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** **16. SOCIAL SECURITY NO.** _____ **17. INFORMANT'S SIGNATURE OR NAME** _____ **ADDRESS** _____

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) **Arterio-sclerosis; Myocardial infarction**
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) **Hypertension**
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. **Infarction - old**

19a. DATE OF OPERATION _____ **19b. MAJOR FINDINGS OF OPERATION** _____ **20. AUTOPSY?** YES NO

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)** _____ **4201**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ **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 **19** to **May 31, 1943**, that I last saw the deceased alive on **July 4, 1942**, and that death occurred at **1:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **M. C. ...** **23b. ADDRESS** **Slater Mo.** **23c. DATE SIGNED** **1943-5-31**

24a. BURIAL, CREMATION, REMOVAL (Specify) **June 2-53** **24b. DATE** _____ **24c. NAME OF CEMETERY OR CREMATORY** **Slater City Cemetery** **24d. LOCATION** (City, town, or county) **Slater Mo** (State) _____

DATE REC'D BY LOCAL REG. **6-1-1953** **REGISTRAR'S SIGNATURE** **Mrs. Earl C. ...** **25. GENERAL DIRECTOR'S SIGNATURE** **J. E. Jones** **ADDRESS** **Slater Mo**

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

1971
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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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 31

P. O. Address State

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.