

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 26 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1629

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Affton</b>		c. CITY OR TOWN <b>Affton</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>2 1/2 Yrs.</b>		e. STREET ADDRESS (If rural, give location) <b>4313 Garden Park Ct. #820</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4313 Garden Park Ct.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>IDA</b> b. (Middle) <b>A.</b> c. (Last) <b>BREHME</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Jun 11 1953</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>March 17, 1883</b>		9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>Unknown Lingren</b>		13b. MOTHER'S MAIDEN NAME <b>Christine Pearson</b>		14. NAME OF HUSBAND OR WIFE <b>William A. Brehme</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>William A. Brehme 4313 Garden Pk. Ct</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary thromboses</b>		DUPLICATE OF (b) <b>Mitral insufficiency (Decompensated)</b>			<b>5 yrs</b>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUPLICATE OF (c) _____			<b>28 yrs</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>4210</b>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>In 1925 Operation for Mitral Fibroid</b>			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) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____		

22. I hereby certify that I attended the deceased from 1925, 19\_\_\_\_, to June 11, 1953, that I last saw the deceased alive on June 11, 1953, and that death occurred at 3:10 P.M. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Walter K. Kirchner M.D.</b>		23b. ADDRESS <b>508 N. Grand Blvd.</b>		23c. DATE SIGNED <b>6/12/53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal (Mtn)</b>		24b. DATE <b>6-15-1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. John Evangelical</b>	
				24d. LOCATION (City, town, or county) (State) <b>St. Charles, Mo.</b>	

DATE REC'D BY LOCAL REG. <b>6-12-53</b>		REGISTRAR'S SIGNATURE <b>Harold R. Gomb M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Kriegshauser 4228 S. Kingshighway Bl.</b>	
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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.....  
Signature of Student Embalmer

Signed *Edwin A. M. Bennett*

Licensed Embalmer No. *302*

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