

FILED MAY 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17092**

BIRTH NO. **18194-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4399**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. CITY OR TOWN St. Louis 2328	
c. LENGTH OF STAY (In this place township) 2 mos. 5 da.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's		e. STREET ADDRESS (If rural, give location) 1151 Kingsland	
3. NAME OF DECEASED (Type or Print) a. (First) Michael b. (Middle) Patrick c. (Last) Brunk		DATE OF DEATH (Month) (Day) (Year) 5-16-54	
5. SEX M	6. COLOR OR RACE W	7. MARRIED-NEVER MARRIED () WIDOWED, DIVORCED ()	8. DATE OF BIRTH 3-9-1954
9. AGE (In years last birthday) 23		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY -	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John P. Brunk		13b. MOTHER'S MAIDEN NAME Sue Scott	14. NAME OF HUSBAND OR WIFE -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME ADDRESS E. Warner 500 S. English
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) Septicemia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) atonia of ileum 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 7562		22. I hereby certify that I attended the deceased from 3-11 , 1954, to 5-16 , 1954, that I last saw the deceased alive on 5-16 , 1954, and that death occurred at 10:22 pm. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Hulda J. Wohltmann, M.D.		23b. ADDRESS 500 So. Kingshwy	
23c. DATE SIGNED 5/17/54		24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	
24b. DATE 5-17-54		24c. NAME OF CEMETERY OR CREMATORY VAI HALL CEM.	
24d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. W. Clark 1125 HODIAMONT	
DATE REC'D BY LOCAL REG. MAY 17 1954		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

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

