

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35181

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8777**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>House Springs</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>House Springs</b>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>no name</b>	b. (Middle)	c. (Last) <b>Brouk</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>9-20-54</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>9-20-54</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins. <b>2 0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Charles Brouk</b>	13b. MOTHER'S MAIDEN NAME <b>Eileen Brackmann</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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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 <b>Charles Brouk, House Springs, Mo.</b>	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Respiratory &amp; Cardiac Failure</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Prematurity (5mos gest)</b> DUE TO (c) <b>None</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION: <b>None</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>7735</b>
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22. I hereby certify that I attended the deceased from **9-20, 1954**, to **9-20, 1954**, that I last saw the deceased alive on **9-20, 1954**, and that death occurred at **1:20 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>M. O. Brouk</b>	23b. ADDRESS <b>634 N. Grand</b>	23c. DATE SIGNED <b>9.21.54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>9-21-54</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>House Springs, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>SEP 27 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Brimmer, House Springs, Mo.</b>	ADDRESS
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S.P. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY USING SEALING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*[Handwritten Signature]*

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.