

FILED JAN 17 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41863**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11458**

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 town) St. Louis		c. LENGTH OF STAY (in this place) 5 days	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) H. c. (Last) Breuning		4. DATE OF DEATH (Month) (Day) (Year) Dec 28 1955	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Nov. 19 1870
9. AGE (In years) (Month) (Day) (Hour) (Min.) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) grocer	
10b. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (City and State or Foreign Country) Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Christopher Breuning	13b. MOTHER'S MAIDEN NAME Theresa	14. NAME OF HUSBAND OR WIFE Theresa
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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) no	16. SOCIAL SECURITY NO. 492 32 4222	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Theresa Breuning 2904a Sullivan
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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 6 1/2
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease		
	ANTECEDENT CAUSES Arteriosclerotic heart disease		
	DUE TO (b) a.m.		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Bronchopneumonia Conditions contributing to the death but not related to the disease or condition causing death.		4 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 420.0	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)
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?

22. I hereby certify that I attended the deceased from **Dec 22, 1955**, to **Dec 28, 1955**, that I last saw the deceased alive on **Dec 24, 1955**, and that death occurred at **2:40 Am.**, from the causes and on the date stated above.

23a. SIGNATURE C.G. VOITNB	(Degree or title) md	23b. ADDRESS 539 N. Grand	23c. DATE SIGNED 12 28 55
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 12/30/55	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo
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DATE REC'D BY LOCAL REG. DEC 29 1955	REGISTRAR'S SIGNATURE J. C. Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Buchholz Mortuary 5967W. Florissant
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(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 Student Embalmer No. working under my personal supervision.:

Student
Signature of Student Embalmer

Signed *Walter R. ...*

Licensed Embalmer No. *453*

P. O. Address *St. Louis*

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.