

FILED JAN 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2621

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 371

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>St. Louis</u>	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 <u>ST. LOUIS CITY HOSPITAL #1.</u>		e. STREET ADDRESS (If rural, give location) <u>15 4649 Minnesota</u>	

3. NAME OF DECEASED (Type or Print) <u>BARBARA BRUDER</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 10, 1956.</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>	8. DATE OF BIRTH <u>2/2/1868</u>	9. AGE (In years last birthday) Months Days <u>87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>John Gubitz</u>	13b. MOTHER'S MAIDEN NAME <u>Unk.</u>	14. NAME OF HUSBAND OR WIFE <u>Fred (Deceased)</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Julius Grimm 4507 Alaska</u>

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, ashenia, 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) <u>Infection of left cerebral hemisphere</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral artery thrombosis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>332x</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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 1-8, 1956, to 1-10, 1956, that I last saw the deceased alive on 1-10, 1955, and that death occurred at 8:25p m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. E. Taylor M.D.</u>	(Degree or title)	23b. ADDRESS <u>1515 LAFAYETTE AVE.</u>	23c. DATE SIGNED <u>1-11-56.</u>
--	-------------------	--	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>1/11/56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Forest Home Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Chicago Ill</u>
---	-----------------------------	---	---

DATE REC'D BY LOCAL REG. <u>JAN 11 1956</u>	REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm Schumacher 3013 Meramec</u>
--	---	---

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.....
Licensed Embalmer No. 274

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.