

FILED MAY 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH14472
State File No.

318

1003

Registrar's No. 3758

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 1 month		c. CITY OR TOWN Overland		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 Faith Hospital				e. STREET ADDRESS (If rural, give location) 3534 Dix Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) Elmer c. (Last) M. Bracksieck			4. DATE OF DEATH (Month) (Day) (Year) April 14, 1956				
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 7, 1899		9. AGE (In years last birthday) 56yrs	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) Foreman St. Louis Car Co.			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Edward Bracksieck			13b. MOTHER'S MAIDEN NAME Rose Schwartz		14. NAME OF HUSBAND OR WIFE Mrs. Agnes Bracksieck		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No None		16. SOCIAL SECURITY NO. 493-05-4937		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Agnes Bracksieck 3534 Dix Ave.			
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anaplastic Carcinoma of both lungs.			INTERVAL BETWEEN ONSET AND DEATH _____
				ANTECEDENT CAUSES Afordid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. generalized metastasis			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 162x				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) (Min.) _____		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 3-16, 1956 to 4-15, 1956 that I last saw the deceased alive on 4-15, 1956 and that death occurred at 2 P. m. , from the causes and on the date stated above.							
23a. SIGNATURE Dr. W. G. Bernard M.D. (Degree or title)				23b. ADDRESS 3409 N. Union		23c. DATE SIGNED 4-16-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE April 17, 1956	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.		
DATE REC'D BY LOCAL REG. APR 16 1956		REGISTRAR'S SIGNATURE Charles Smith W. G. Alexander & Son		25. FUNERAL DIRECTOR'S SIGNATURE Charles Smith W. G. Alexander & Son		ADDRESS 6175 Delmar	

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Berwald
3409 Union
Co 1 2582 } 1.30

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: *jos. E. McCulloch*

Licensed Embalmer No. *24*

P. O. Address *61307*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.