

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011413  
STATE FILE NUMBER  
3253

FILED APR 9 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300  
-57

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Bros. Hosp.</b>		Length of stay in lb <b>65 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>3733 French Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ADOLPH</b> Middle <b>F.</b> Last <b>BRUNNER</b>			4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1883</b>	9. AGE (In years last birthday) <b>74</b>	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) <b>retired custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lutheran Church</b>	11. BIRTHPLACE (City and state or country) <b>Maxville, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Adolph Brunner</b>		13b. MOTHER'S MAIDEN NAME <b>Katie Schnarbus</b>		14. NAME OF HUSBAND OR WIFE <b>Callie Gibson Brunner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. Callie Brunner 3733 French Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>					<b>yr.</b>
DUE TO (c) <b>332x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pulmonary Infection</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>Feb 1958</b> to <b>March 19 1958</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>3-17-58</b> Death occurred at <b>7:00 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>John J. Orshly M.D.</b> (Degree or title)			22b. ADDRESS <b>520 Chippewa</b>		22c. DATE SIGNED <b>3-19-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>removal</b>	<b>Mar. 21, 1958</b>	<b>St. Trinity Cemetery</b>		<b>St. Louis County, Missouri</b>	
24. FUNERAL DIRECTOR <b>BEIDERWIEN F. H. INC., 1936 St. Louis Ave</b>			25. DATE RECD. BY LOCAL REG. <b>MAR 20 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Paul Smith, M.D.</b> <i>m.p.d.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Locality, manner, etc. must be causally related. All diseases in Part I must be causally related.

Dr. John J. Inkley  
5203 Chippewa St.,

PP 2-0632  
6:30-8 P.m.  
1-3pm 2nd

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. 4520  
P. O. Address St. Louis, Mo.

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.