

Health,
& Welfare
Public
Service

FILED APR 9 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011678
STATE FILE NUMBER
3505

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

300
1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>5441 N. Euclid</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <u>Catherine</u>	Middle	Last <u>Graef</u>	Month <u>March</u>	Day <u>26</u> Year <u>1958</u>

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 6, 1884</u>	9. AGE (In years last birthday) <u>74</u> Months <u>0</u> Days <u>20</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>WILLIAM BRUEGGEDAHEN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>HAROLD GRAEF</u> Address <u>4926 Ashby</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>Permeous Anemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) <u>290.0</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>1</u>
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20c. TIME OF INJURY Hour a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT 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
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21. I attended the deceased from Mar. 9, 1958 to Mar. 26, 1958 and last saw ^{her} him alive on Mar. 26, 1958
Death occurred at 3:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Carol M. Bernstein MD</u> (Degree or title)	22b. ADDRESS <u>1515 Lafayette</u>	22c. DATE SIGNED <u>3/26/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAR 29, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo</u> (State)
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24. FUNERAL DIRECTOR <u>Bromschwig & Son 4746 Florissant</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MAR 27 58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>mrb.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

any statements made in item 18. No symptoms will be listed. If must be causally related.

MEDICAL CERTIFICATION

MA 01.03

STATE OF MASSACHUSETTS

PLATE NO.

NO.

PLATE NO.

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 *John J. Hume*

Licensed Embalmer No. *4108*
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.