

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015587
State File No.

FILED MAY 1 1958

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 4504

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 township) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 10 mo.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 26 St. Louis Chronic Hospital 69 5718 Cote Brillante			
3. NAME OF DECEASED (Type or Print) a. (First) Anna		b. (Middle) Brockman	
c. (Last) Brockman		4. DATE OF DEATH (Month) (Day) (Year) 4-24-58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH Dec. 5, 1876
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months Days	IF UNDER 1 HS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Matron		10b. KIND OF BUSINESS OR INDUSTRY School Board	11. BIRTHPLACE (City and State or Foreign Country) Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME August ? Puls	
13b. MOTHER'S MAIDEN NAME Anna Hunzel		14. NAME OF HUSBAND OR WIFE unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ida Ernzen 1074 Fontaine Pl.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Renioarteriole Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>600.04</u>	
DUE TO (c) <u>Pyelonephritis</u>		I. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Basal Cell C.A. Cancer</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)		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 <u>6-12-57</u> , 19___, to <u>4-24-58</u> , 19___, that I last saw the deceased alive on <u>4-24-58</u> , 19___, and that death occurred at <u>4:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>John W. Beckham, M.D.</u>		23b. ADDRESS <u>5800 Arsenal St.</u>	
23c. DATE SIGNED <u>4/25/58</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>4-28-1958</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jos. W. Clark F.H. 1125 Hodiamont</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>APR 25 58</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jos. W. Clark F.H. 1125 Hodiamont</u>	

WRITE PLAINLY—USING UNFADEING 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..... *Alfred J. Breda*.....

Licensed Embalmer No. *26*.....

P. O. Address *1125 1/2*.....

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.