

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024046  
STATE FILE NUMBER

FILED JUL 11 1958 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1688

300  
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		5. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Richmond Heights 44950 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp.		Length of stay in 1b 3 days	d. STREET ADDRESS (If outside, give location) 7830 Wise Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last LOUISE C. BREMSER			4. DATE OF DEATH Month Day Year June 22, 1958	
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1893	9. AGE (In years last birthday) 64	10. FUNDING YEAR 11 24	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Charleston, W. Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Marion Raike	13b. MOTHER'S MAIDEN NAME Mable Tawney	14. NAME OF HUSBAND OR WIFE Clifford V. Bremser
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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) No	16. SOCIAL SECURITY NO. 490-18-8718	17. INFORMANT Clifford V. Bremser, 7830 Wise Ave.
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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) <i>Acute Myocardial Infarction</i> <i>arteriosclerotic heart disease</i> <i>hypertension</i> <i>slight hemiplegia - 1948 and</i> <i>slight residual effect of the hemiplegia in 1956</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4301</i>		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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 <u>1948</u> to <u>June 22, 1958</u> and last saw her <sup>her</sup> <sub>alive</sub> on <u>June 22, 1958</u> Death occurred at <u>4:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>H. Williamson</i> (Degree or title) M D	22b. ADDRESS 6336 Clayton Rd.	22c. DATE SIGNED 6/23/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 25, 1958	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri
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24. FUNERAL DIRECTOR Ambruster Mortuary, 6633 Clayton Rd.	25. DATE RECD. BY LOCAL REG. 6/24/58	26. REGISTRAR'S SIGNATURE <i>Herbert R. Dombek M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Arvid J. Hammer* .....

Licensed Embalmer No. *4788* .....

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.