

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046748

STATE FILE NUMBER

FILED DEC 19 1958

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 3066

300
1-57

1. PLACE OF DEATH a. COUNTY St. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN GARDENVILLE		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN St. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MILLER NURSING HOME		Length of stay in lb 1/57	d. STREET ADDRESS (If outside, give location) 5420 DRESDEN
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First WILLIAM Middle C Last BRANT	4. DATE OF DEATH Month Nov Day 21 Year 1958
---	---

5. SEX MALE 0	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 JULY 13, 1867	9. AGE (In years last birthday) 91	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) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) CAPE GIRARDEAU, Mo	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	--

13a. FATHER'S NAME NOT KNOWN	13b. MOTHER'S MAIDEN NAME NOT KNOWN	14. NAME OF HUSBAND OR WIFE MINNIE
--	---	--

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. 486-14-6656	17. INFORMANT MINNIE BRANT Address 5420 DRESDEN
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, right internal carotid artery		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis general & cerebral		10 yrs
	DUE TO (c) 334X		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia		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: Month, Day, Year a.m. p.m.
--

20d. INJURY OCCURRED WHILE AT <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
---	--	---

21. I attended the deceased from January 1957 to 21 Nov 58 and last saw him alive on 18 Nov 58 Death occurred at 21 Nov 58 9:00a m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Wesley B. Brown M.D.	22b. ADDRESS 110 S. Central Clayton 5	22c. DATE SIGNED 22 Nov 58
---	---	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/24/1958	23c. NAME OF CEMETERY OR CREMATORY ST. PAUL CHURCHYARD	23d. LOCATION (City, town, or county) (State) ST. LOUIS Co., Mo.
--	--------------------------------	--	--

24. FUNERAL DIRECTOR J L ZIEGENHEIN & SONS ADDRESS 7027 GRAVOIS	25. DATE RECD. BY LOCAL REG. 11-24-58	26. REGISTRAR'S SIGNATURE Herbert R. Blomke, M.D.
--	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Donald E. Bering*

Licensed Embalmer No.

P. O. Address *H. J. Bering*

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.