

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006924
STATE FILE NUMBER

1906
Registrar's No.

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____

| | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE DOA City Hospital | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) 4522a Morganford | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Cecelia Ellen Brake | | | 4. DATE OF DEATH Month Day Year Feb. 22, 1959 | | | |
| 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 October 29, 1891 | 9. AGE (In years last birthday) 67 | IF UNDER 1 YEAR Months Days 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 Housewife | 11. BIRTHPLACE (City and state or country) Brooklyn, N.Y. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME James Lavelle | | 13b. MOTHER'S MAIDEN NAME Unknown Bradshaw | | 14. NAME OF HUSBAND OR WIFE Bernard G. Brake | | |
| 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. | 17. INFORMANT Address Bernard G. Brake 4522a Morganford | | | |
| 18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <i>Hypertension</i> | DUE TO (c) <i>420.1</i> | 6-24-55 | | |
| 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 type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 |
| 21. I attended the deceased from <i>6-24-55</i> to <i>2-22-59</i> and last saw ^{her} alive on <i>2-20-59</i> Death occurred at <i>5:00</i> P.m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE <i>R. Lund</i> (Degree or title) | | | 22b. ADDRESS <i>5417 So Grand Blvd</i> | | 22c. DATE SIGNED <i>2/23/59</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Feb. 25, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | |
| 24. FUNERAL DIRECTOR ADDRESS BEIDERWIEDEN F.H., Inc., 1936 St. Louis Ave. | | | 25. DATE RECD. BY LOCAL REG. FEB 24 '59 | 26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> <i>m.l. B</i> | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. Ernest H. Ruml
922 3-5511
5717 S. Grand
12-12-30 - 5:30pm Mon.

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 Homer W. Fritz

Licensed Embalmer No. 3882
P. O. Address St. Louis

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.