

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006932

STATE FILE NUMBER

2 1253

FILED FEB 17 1959 Registration District No. Primary Registration District No. Registrar 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
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Length of stay in 1b 20 years	d. STREET ADDRESS (If outside, give location) 8721 Halls Ferry Rd.
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Mary Brockman	4. DATE OF DEATH Month Day Year February 4 1959
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5. SEX Female 1	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1873	9. AGE (In years - last birthday) 85	IF UNDER 1 YEAR Months Days	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) Illinois	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Frank Goehrs	13b. MOTHER'S MAIDEN NAME Minnie Meierhoff	14. NAME OF HUSBAND OR WIFE Fred Brockman
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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. None	17. INFORMANT Edward Piehl	Address 8721 Halls Ferry Rd.
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18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6. weeks</i>
DUE TO (b) _____		
DUE TO (c) <i>420.0F</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Fracture - l. hip</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.) <i>Fall</i>
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20c. TIME OF INJURY <i>4:50 a.m.</i>	Hour Month, Day, Year <i>1-11-59</i>
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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.) <i>Lutheran Home 8721 Halls Ferry Rd - St. Louis, Mo.</i>	20f. CITY, TOWN, OR LOCATION <i>St. Louis, Mo.</i>	COUNTY	STATE
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21. I attended the deceased from <i>January 1</i> to <i>Feb 4 59</i> and last saw her alive on <i>Feb 4 59</i> Death occurred at <i>2:00 p.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>R. M. ...</i>	(Degree or title) <i>M.D.</i>	22b. ADDRESS <i>3701 Grand St</i>	22c. DATE SIGNED <i>2-5-59</i>
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23a. BURIAL, CREMATION, REMOVAL <i>Removal</i>	23b. DATE <i>Feb. 9, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Woodburn, Oregon Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Woodburn, Oregon</i>
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24. FUNERAL DIRECTOR <i>Beiderwieden F.H.Inc. 1936 St. Louis</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>FEB 5 '59</i>	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>
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892
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USE ONLY BLACK INK OR RIBBON IN REWRITE IF POSSIBLE

Medical Certificate
All diseases in Part I must be causally related

Secretary, County, etc. 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 _____

Licensed Embalmer No. 455
P. O. Address _____

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.