

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010745

STATE FILE NUMBER

FILED APR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. **3157**

300
1-57

How patient on day of death for Dr. Hendler to his physician. POSSIBLE CAUSE OF DEATH. USE ONLY BLANK OR WHITE PAPER. ALL diseases in Part I must be causally related.

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5215a S. Grand		d. STREET ADDRESS (If outside, give location) 5215a S. Grand	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First OTTO Middle W. Last BRIX		Month Mar. Day 28 Year 1959	
5. SEX Male	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 June 28, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-H. & H. Motor Co.		11. BIRTHPLACE (City and state or country) Washington, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Brix		13b. MOTHER'S MAIDEN NAME Ida B. Voss	14. NAME OF HUSBAND OR WIFE Dorothy Brix
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. 489-05-1996	17. INFORMANT Address Dorothy Brix 5215a S. Grand
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE, (a) Myocardial infarction (b) 420.1 (c) 3/28/59 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Asthma			INTERVAL BETWEEN ONSET AND DEATH 1 hour
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 _____ a.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 3/28/59 to 3/28/59 and last saw her alive on _____ Death occurred at 7.00 a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Harry A McLean MD		22b. ADDRESS 4924 Hampton Ave, St Louis 9	22c. DATE SIGNED 3/28/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Mtr)	23b. DATE Mar. 31, 1959	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	23d. LOCATION (City, town, or county) (State) Washington, Mo.
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. MAR 30 '59	26. REGISTRAR'S SIGNATURE Harold Smith MD

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 *William B. White*

Licensed Embalmer No. *1281*

P. O. Address *4228 S. ...*

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.