

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018981
STATE FILE NUMBER
2 4360

FILED MAY 18 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57
3
7
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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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SPARTA</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>Route # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>L.</u> Last <u>BRENNING</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 27, 1921</u>
9. AGE (In years last birthday) <u>37</u>		10. FUNDING YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	11. BIRTHPLACE (City and state or country) <u>Pency, Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Henry Brenning</u>	
13b. MOTHER'S MAIDEN NAME <u>Clara Schander</u>		14. NAME OF HUSBAND OR WIFE <u>H. Brenning</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>	17. INFORMANT <u>Henry Brenning, Sparta, Ill.</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>			<u>2 YEARS</u>
DUE TO (c) <u>420.1</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>DIABETES MELLITUS. KIMMELSTEIL-WILSON'S DISEASE</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>APRIL 22, 1959</u> to <u>MAY 2, 1959</u> and last saw her/him alive on <u>MAY 2, 1959</u> Death occurred at <u>10:05 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>F.R. Bradley</u> (Degree or title) <u>M. D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>5/3/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-3-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Paradise Cemet.</u>	23d. LOCATION (City, town, or county) (State) <u>Steelville, Ill.</u>
24. FUNERAL DIRECTOR <u>Schack, Steelville, Ill.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>MAY 4 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

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 *Lawrence M. Bult*

Licensed Embalmer No. *4375*
P. O. Address *St. Louis 23 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.