

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 31 1959

59-030266

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7381** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived/If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b	c. CITY OR TOWN LEMAY		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKES HOSP.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 929 REAR DAMMERT		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RANDY Middle CHARLES Suffix BRAUCH			4. DATE OF DEATH Month AUG Day 7 Year 1959		
5. SEX M	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-4-1959	9. AGE (last birthday) 2 Months 1 Days	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST. LOUIS, Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME DONALD J. BRAUCH JR.		13b. MOTHER'S MAIDEN NAME ELSIE BAKER		14. NAME OF HUSBAND OR WIFE -	
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 ELSIE BRAUCH Address 924 REAR DAMMERT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE					INTERVAL BETWEEN ONSET AND DEATH 36 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CONGENITAL HEART DEFECTS - PULMONARY STENOSIS & LARGE INTRAVENTRICULAR SEPTAL DEFECT DUE TO (c) 754.2					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year					
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 BIRTH - 8-4-59 , to 8-7-59 and last saw him alive on 8-7-59 Death occurred at 3:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) James F. H. Clark, Jr. M.D.			22b. ADDRESS 905 FAIRMORE AVE., ST. LOUIS 19		22c. DATE SIGNED 8-7-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE AUG 8, 1959	23c. NAME OF CEMETERY OR CREMATORY ST. MATTHEWS CEM.		23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo
24. FUNERAL DIRECTOR Thomas Kute ADDRESS 2906 Graciev		25. DATE RECD. BY LOCAL REG. AUG 8 '59		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFRAVIT OF

2MBB

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Thomas F. Clinch

Licensed Embalmer No. _____

P. O. Address _____

Not Embalmed

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.