

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033604

FILED VS SEP 16 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7984**

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If outside, give location) 535 Clara Ave.	

3. NAME OF DECEASED (Type or print) First ISADORE Middle Last BRASCH			4. DATE OF DEATH Month August Day 27 Year 1959		
5. SEX Male	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 5/12/80	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cutter		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (City and state or country) Berlin Germany	

13a. FATHER'S NAME Jacob Karl Brasch		13b. MOTHER'S MAIDEN NAME Henrietta Rosentretter		14. NAME OF HUSBAND OR WIFE Lillie S. Brasch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Irwin Brasch 6722 Crest Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 <input checked="" 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.) Suffered in fall down steps	
20c. TIME OF INJURY Hour 8:22 Month, Day, Year 59 in front of house on Aug 22, 1959.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 121 W. Olive		20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Mo	

21. I attended the deceased from **315 A** to _____ and last saw him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Of Declarant) Paul Simon		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 8/28/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8/28/59		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	
24. FUNERAL DIRECTOR Herman Rindskopf, Inc. 5216 Delmar		25. DATE RECD. BY LOCAL REG. AUG 28 59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.P.

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

Peter B. Dubrovec

Licensed Embalmer No. *3291*

P. O. Address *Henry M*

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.