

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041619

FILED VS NOV 19 1959

210234

STATE FILE NUMBER

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

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>				Length of stay in 1b		c. CITY OR TOWN <i>St. Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Desloge Hosp</i>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>7621 Palm</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Marie E. Bruening</i>				4. DATE OF DEATH Month Day Year <i>11-6-1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>11-8-1880</i>	9. AGE (last birthday) <i>78</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (City and state or country) <i>St. Louis Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>John Bernhardt</i>			13b. MOTHER'S MAIDEN NAME <i>Elizabeth Brockord</i>		14. NAME OF HUSBAND OR WIFE <i>Joseph Bruening</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Joseph Bruening - 2621 Palm</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Cerebral thromboses - multiple</i>						<i>3 1/2 wks</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Cerebral arteriosclerosis</i>						<i>1 yr.</i>	
DUE TO (c) <i>332x</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <i>Bronchopneumonia (terminal)</i>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <i>10-21-59</i> to <i>11-6-59</i> and last saw her alive on <i>11-6-59</i> Death occurred at <i>10:15 P</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>George A. Make MD</i>				22b. ADDRESS <i>950 Francis Pl.</i>		22c. DATE SIGNED <i>11-7-59</i>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE <i>11-9-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>		23d. LOCATION (City, town, or county) <i>St. Louis, Mo</i>		
24. FUNERAL DIRECTOR <i>Edw Kochson - 2516 N. 14th</i>				25. DATE RECD. BY LOCAL REG. <i>NOV 7 1959</i>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

P.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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarence M. Bille

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.