IRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 1 1 1960

-60-007978

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2199

NDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 5824 Goener Ave.

Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY

c. CITY OR TOWN: St. Louis

Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 5824 Goener Ave.

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)
First: MATHILDA
Middle:
Last: BRAUKS

4. DATE OF DEATH: Month: Feb. Day: 24 Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: Sep. 24, 1871

9. AGE (last birthday): 88

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HR: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (City and state or country): Red Bud, Ill.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Unknown Rathert

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Late William Brauks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edna R. Schwarz
Address: 5824 Goener Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SENILE INANITION — INTERVAL BETWEEN ONSET AND DEATH: 6 MOS.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): GENERALIZED ARTERIOSCLEROSIS — 5 YEARS

DUE TO (c): HIATUS HERNIA — 3 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 450.0

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 1-2-56, to 2/24/60 and last saw her/him alive on 1-28-60

Death occurred at 2:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Charles B. Ladd MD (Degree or title)

22b. ADDRESS: 7430 Virginia Ave

22c. DATE SIGNED: 2/25/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: Feb. 26, 1960

23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park

23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Kriegshauser
ADDRESS: 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG.: FEB 25 1960

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 453

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.