

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017855

FILED VS APR 29 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1261 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>AFTON</u>		Length of stay in 1b <u>2 WEEKS</u>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MILLER NURSING HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5424 RHODES</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>(N.M.I.)</u> Last <u>BRAUN</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/1880</u>	9. AGE (last birthday) <u>79</u>	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) <u>HOUSEWIFE (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY <u>NAT'L</u>	
13a. FATHER'S NAME <u>BROUN KOENIG</u>		13b. MOTHER'S MAIDEN NAME <u>(UNKNOWN) WALTHERS</u>		14. NAME OF HUSBAND OR WIFE <u>FRED BRAUN (DECEASED)</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>NONE</u>	17. INFORMANT Address <u>WALTER BRAUN, 5424 RHODES, ST. LOUIS, MO.</u>			

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) <u>Acute Myocarditis</u>		<u>3 Days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Arteriosclerosis</u>	<u>2 Mo.</u>
	DUE TO (c) <u>Chronic Nephritis</u> <u>592x</u>	<u>2 Mo.</u>
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 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 April 3 1960 to April 16 1960 and last saw ^{her} him alive on April 16 1960
Death occurred at 12:00 NOON m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W. H. Walters M.D.</u>	22b. ADDRESS <u>3608 South Grand Blvd.</u>	22c. DATE SIGNED <u>4/19/60</u>
23a. BURIAL CREATION, CEMETERY, OR CREMATORY <u>OAK GROVE MAUSOLEUM</u>	23b. DATE <u>4/19/1960</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, MISSOURI</u>

24. FUNERAL DIRECTOR ADDRESS <u>HOFFMEISTER COLONIAL MORTUARY</u> <u>6464 CHIPPEWA STREET, ST. LOUIS, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>4-18-60</u>	REGISTRAR'S SIGNATURE <u>John B. M... M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

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 _____
Signature of Student Embalmer

Signed *Eric C. Branson*

Licensed Embalmer No. 4769

P. O. Address St. Louis

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.