

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 27 1960

-60-024365

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5840**

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. Louis		Length of stay in 1b		c. CITY OR TOWN ST. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4236 ARSENAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4236 ARSENAL		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle BRUCKNER Last				4. DATE OF DEATH Month JUNE Day 5 Year 1960									
5. SEX FEMALE		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 9-26-1872		9. AGE (last birthday) 87		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) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME CASPER WOLBRINK				13b. MOTHER'S MAIDEN NAME CAROLINE ROTH				14. NAME OF HUSBAND OR WIFE Edward BRUCKNER (Dec'd)					
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. No		17. INFORMANT Address DR. CORINNE BRUCKNER 4236 ARSENAL							
18. CAUSE OF DEATH (Enter only one cause per line for: (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, left breast Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. with Metastases. DUE TO (b) Intestinal Obstruction 2 days DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 170x								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 1-30-60 to 6-5-60 and last saw her him alive on 6-4-60 Death occurred at 10:55 P m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Edward P. Ketting M.D.						22b. ADDRESS 950 Francis Pl.				22c. DATE SIGNED 6-8-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE June 8 1960		23c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES Cem.		23d. LOCATION (City, town, or county) ST. Louis Co Mo		(State)					
24. FUNERAL DIRECTOR Thomas Ratis 2966 Grand				25. DATE RECD. BY LOCAL REG. 6-7-1960		26. REGISTRAR'S SIGNATURE Carl Smith, M.D.							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2-4 Well
6-7

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 Eleana Horine

Licensed Embalmer No. 3403

P. O. Address 2906 Grand

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.