

STATE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034342

FILED VS OCT 16 1960

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 221

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>GASCONADE</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON</u>		Length of stay in 1b <u>2 YRS</u>	c. CITY OR TOWN <u>Richland TWP.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. FRANCIS HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2 mi. W. of PERSHING</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHRISTINA</u> Middle <u>DORA</u> Last <u>BRACHT</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/1883</u>	9. AGE (last birthday) <u>77</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>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>	11. BIRTHPLACE (City and state or country) <u>Swiss Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>John Stortz</u>		13b. MOTHER'S MAIDEN NAME <u>CAROLINE EIKERMANN</u>		14. NAME OF HUSBAND OR WIFE <u>Isaac T. Bracht</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>496-40-7711B</u>	17. INFORMANT <u>Isaac T. Bracht</u> <sup>Address</sup> <u>Red Morrison Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
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)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N: <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 <u>1953</u> to <u>Oct. 1, 1960</u> and last saw her/him alive on <u>Oct 1, 1960</u> Death occurred at <u>3:05</u> p on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>George M. Workman M.D.</u>			22b. ADDRESS <u>HERMANN, MO</u>		22c. DATE SIGNED <u>10-3-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10/4/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FREDRICKSBURG E.K. Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Red Morrison Mo</u>			
24. FUNERAL DIRECTOR <u>HUGO H. BLUMER</u>		ADDRESS <u>HERMANN Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10/4/60</u>	26. REGISTRAR'S SIGNATURE <u>George M. Workman</u>		

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 *August Lerner*  
Licensed Embalmer No. 316  
P. O. Address Herrman

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