SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-022345

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5602

FILED JUN 26 1961

DATE AMENDED 5/2

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

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

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b 10 days

c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. John's Hospital — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 1007 Wall Street — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Edward Middle Last Brauss

4. DATE OF DEATH Month Day Year June 14, 1961

5. SEX male

6. COLOR OR RACE white

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 4-14-1884

9. AGE (last birthday) 77 — 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) Retired Electrician

10b. KIND OF BUSINESS OR INDUSTRY St. Louis Car Co.

11. BIRTHPLACE (City and state or country) St. Louis, Missouri

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

13a. FATHER'S NAME Carl W. Brauss

13b. MOTHER'S MAIDEN NAME Anna Goshen

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Mrs. Harold Webb, 5730 Park Lane

MEDICAL CERTIFICATION

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) Cerebral thrombosis — 2 wks

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

DUE TO (b) Cerebral arteriosclerosis unknown

DUE TO (c) 332X

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. ☐ 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 29 May 1961 to death and last saw her/him alive on 13 June 61

Death occurred at 5:30 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R H Bolde MD

22b. ADDRESS Northland Med Bld

22c. DATE SIGNED 6/15/61

23a. BURIAL, CREMATION, REMOVAL (Specify) burial

23b. DATE 6-16-61

23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc. 2161 E. Fair Ave.

25. DATE RECD. BY LOCAL REG. JUN 15 1961

26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 3737

P. O. Address _____

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.