

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D APR 12 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

8319  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791  
(b) Township..... Primary Registration District No. 1003  
(c) City St. Louis, Mo. (d) Street No. Lutheran Hospital St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 2084

2. PRINT FULL NAME

Anna Bruns,  
(a) Residence, No. 4714 Dahlia Ave., St. 2  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Bruns,

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 12th, 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
65 11 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

FATHER 13. NAME Fred Morris,

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Orleans

MOTHER 15. MAIDEN NAME Kate Casper,

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

17. INFORMANT (ADDRESS) Mrs. Regenia Carpenter,  
4714 Dahlia Ave.,

18. BURIAL, CREMATION, OR REMOVAL PLACE New S.S. Peter & Paul Mar. 6th, 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Henry Leidner Und.  
1417 N. Market Street.

20. MAR 4 1939 J.P. Beckwith  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1939, to Mar. 2, 1939

I last saw her alive on March 2, 1939 Death is said to have occurred on the date stated above, at 5:15 P. m.

The principal cause of death and related causes of importance were as follows:

myocarditis, chronic  
127  
Date of onset

Other contributory causes of importance:  
Removal of gall bladder at Lutheran Hospital  
no stones

Name of operation removal gall bladder Date of March 24  
What test confirmed diagnosis? Chem. cal. Was there an autopsy? no.

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? no. Date of injury no., 19no.  
Where did injury occur? (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none  
Nature of injury no.

24. Was disease or injury in any way related to occupation of deceased? no.  
If so, specify none  
(Signed) Wm. R. Nye, M. D.  
(Address) 2931 Trafalgar ave.

EV 10/1/50

1931 Illinois

2528754

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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Harold L. Pender

Licensed Embalmer No. 3367

P. O. Address 2223 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 this body is not embalmed, above space should be left blank.