

23 1939

MAY 25 1939

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

16142
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
(b) Township _____ Primary Registration District No. 111
(c) City St. Louis Rich Hill (d) Street No. St. Marys Hospital Registered No. 929
(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.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME William L. Breuer

(a) Residence, No. 4255 Bates St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Opal Meng Breuer

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 7, 1905

7. AGE YEARS 33 MONTHS 6 DAYS 13 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Seed Salesman
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) St. Louis (STATE OR COUNTRY) Missouri

FATHER 13. NAME William Breuer

14. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Baisch

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wisconsin

17. INFORMANT Opal Breuer (ADDRESS) 4255 Bates

18. BURIAL, CREMATION, OR REMOVAL PLACE Sunset B. Pk. DATE 5/24/39

19. FUNERAL DIRECTOR (NAME) J. L. Ziegenhein & Sons (ADDRESS) 7027 Gravois

20. FILED MAY 23 1939 St. Marys Hospital Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 20, 19 39

22. I HEREBY CERTIFY, That I attended deceased from 4/25, 19 39, to 5/20, 19 39

I last saw him alive on May 20th, 19 39 Death is said to have occurred on the date stated above, at 7:20m. PM
The principal cause of death and related causes of importance were as follows:

- 1. Septicemia staphylococcus.
- 2. Multiple abscesses.

- Other contributory causes of importance:
- 1. Nephritis.
 - 2. Pericarditis.
 - 3. Chronic fibronous pleurisy.

Name of operation None. Date of _____
What test confirmed diagnosis? Lab., etc as there an autopsy? Yes.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? Claimed injury at employment August, 1938 Specify city or town, county, and State)
Specify whether injury occurred in Industry, in home, or in public place.
See above.

Manner of injury Struck back.
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify E. C. ... (Signed) E. C. ..., M. D.
(Address) 4101a Laclede Ave.

STATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

B.C.

10.1.12

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.....

Clarence P. Kidwell

Licensed Embalmer No.

3877

P. O. Address.....

6937 1/2 Shaw

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

16142-
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
(b) Township Richmond Hts. Primary Registration District No. 111 Registered No. 929-
(c) City St. Marys Hosp. (d) Street No. St. Marys Hosp. 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. nos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William L. Bremer -

(a) Residence, No. 4253 Bates - St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M -
(Write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
33 6 13 -

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 20 1934

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw h. alive on 19. Death is said to have occurred on the date stated above, at m.

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

Septicemia Staphylococcus -
Multiple abscesses -
Peri-penit, right; lower extremities
chin and forehead. Date of onset 133d

Other contributory causes of importance:

Nephritis Chr. Pyelitis, Pyelone-
phrositis.
Pericarditis
Chr. fibrous pleurisy

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19

Where did injury occur? Claimed injury at
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Struck back.

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify E. C. Farnach, M. D.

(Address) 4101 Laclede -

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

