

REC'D JUL 19 1939

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

23101
Do not use this space.

1. PLACE OF DEATH 2

(a) County St Charles Registration District No. 257
 (b) Township St Charles Primary Registration District No. 3036 Registered No. 96
 or
 (c) City St Charles (d) Street No. 556 Morgan St 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.

2. PRINT FULL NAME Rev H. F. Braun

(a) Residence, No. 556 Morgan St 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 24, 1887

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>51</u>	<u>6</u>	<u>13</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Minister
 9. Industry or business in which work was done, as saw mill, bank, etc. Church
 10. Date deceased last worked at this occupation (month and year) Oct. 1938
 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Merrell, Wisconsin

FATHER

13. NAME Fred Braun
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kernsey, Mo

MOTHER

15. MAIDEN NAME Nichelmina Rohloff
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Merrell, Wisconsin

17. INFORMANT (ADDRESS) Mrs H. F. Braun
556 Morgan - St. Charles, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Harvans, Wisconsin DATE July 10, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Haekmann - Bauer
St Charles Mo

20. FILED 7/7 19 39 Clarence G. Dressler Local Registrar. 679 (Address) St Charles Mo

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 24, 1939

22. I HEREBY CERTIFY, that I attended deceased from July 1st, 1939, to July 14th, 1939
 I last saw him alive on July 6th, 1939 Death is said to have occurred on the date stated above, at 3:45 m.
 The principal cause of death and related causes of importance were as follows:
Acute dilatation of heart, 2 1/2 W 24hr.

Other contributory causes of importance:
Chronic Myocarditis 1 yr
Glaucoma at death

Name of operation none Date of 2:00
 What test confirmed diagnosis? Autopsy Was 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? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____ (Signed) A. Perich Schmitt, M. D.
St Charles Mo

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.

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.....

Arthur C. Bone

Licensed Embalmer No.....

3115

P. O. Address.....

St Charles Mo

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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

23101
Do not use this space.

1. PLACE OF DEATH *St Charles*
(a) County *St Charles* Registration District No. *75-7*
(b) Township *St Charles* Primary Registration District No. *3236* Registered No. *96*
(c) City *St Charles* (d) Street No. _____ 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.
2. PRINT FULL NAME *HAROLD F Braun*
(a) Residence, No. _____ 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) *m*

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.
51 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 *8/14/39* 19 *Ernest S. Moser* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-7-1939*

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

I last saw him 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:

Date of onset

Other contributory causes of importance:

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? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

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

If so, specify (Signed) *A. P. Schulz*, M. D.

(Address) *St Charles Mo*

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

SUPPLEMENTARY

