

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.

NOV 13 1939
Registration District No. 1005

Primary Registration District No. _____

1. PLACE OF DEATH: 1005
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: 6633 Lansdowne
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether) Life
In this community Life
years, months or days)

3. (a) PRINT FULL NAME Robert Brueggeman Sr.
3. (b) If veteran, name war _____ 3. (c) Social Security No. 489-07-6974

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lillian Brueggeman
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased April 11 1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 5 Days 20
If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Mailer

11. Industry or business Globe-Democrat

MOTHER FATHER
12. Name Fred
18. Birthplace St. Charles Co Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Luenebrink
15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Lillian Brueggeman
(b) Address 6633 Lansdowne

17. (a) Burial (b) Date thereof 10 4 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director C. Hoffmann
(b) Address 7814 S. Broadway

19. (a) OCT 3 1939 (b) J. B. ...
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 1
(c) City or town St. Louis 3
(If outside city or town limits, write "RURAL")
(d) Street No. 6633 Lansdowne
(If rural, give location)
(e) If foreign born, how long in U. S. A. Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11 hour 4 minute 45 P. M.
year 1939

21. I hereby certify that I attended the deceased from July 15 1939 to Oct 15 1939
that I last saw him alive on Oct 15 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 2 days

Due to arteriosclerosis

Due to arteriosclerosis
Other conditions Arteriosclerosis 1 Year
(Includes pregnancy within 3 months of death)

Major findings: Arteriosclerosis
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur (near about home, on farm, in industrial place, in public place)? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature J. B. ... (M. D. or other) _____
Address 1537 P. ... Date signed 10/31/39



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 Edwin H. Leibinger

Licensed Embalmer No. 4046

P. O. Address 6464 Clippewa

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.