

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Homer W. Breitenbach
3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 14th 1898
(Month) (Day) (Year)

8. AGE: Years 41 Months - Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation laborer

11. Industry or business Adams Laboratories

12. Name Joseph F. Breitenbach

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

14. Maiden name Emma Kerner
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Geo. Breitenbach
(b) Address 3632 E. Dover St.

17. (a) Burial (b) Date thereof Oct. 30-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Bromberg & Sons
(b) Address 4746 N. Florissant Ave
19. (a) OCT 28 1939 (b) J. F. Breitenbach
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

No physician in attendance
(a) State Mo. (b) County _____
(c) City or town St. Louis _____
(If outside city or town limits, write "RURAL")
(d) Street No. North Side Y.M.C.A. 3100 N. LEANING BLDG
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26th
year 1939 hour 12:30 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Traumatic hemorrhage due to fracture of skull when he staggered & fell on his head on the sidewalk in front of 111 N. 22nd St about 5:00 P.M. Duration _____
Due to _____
Due to on October 25, 1939

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations 1860
Of autopsy 39

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) Accident

(b) Date of occurrence October 25, 1939

(c) Where did injury occur? St. Louis, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Yes Public Place
(Specify type of place) (Specify means of injury)

23. Signature W. H. Perry (M. D. or other) _____
Address 1247 E. 12th St Date signed 10-28-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Guy W Wilkinson

Licensed Embalmer No. 3575

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 this body is not embalmed, above space should be left blank.