

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2879

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town Saint Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
2609 S. Grand Blvd. Memorial Home  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7 years 3  
(Specify whether)  
 In this community 64  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town Saint Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2609 S. Grand Blvd.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. 64 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 26  
 year 1940 hour 5 minute 15 P. M.  
 21. I hereby certify that I attended the deceased from Mar. 23, 1940  
 \_\_\_\_\_, 19\_\_\_\_, to Mar. 28, 1940  
 that I last saw him alive on Mar. 26, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 4 days

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 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 in or about home, on farm, in industrial place, in public place?

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

23. Signature Edward Welby (M. D. or other) M.D.  
 Address 4963 Fountain Date signed 3/27/40

3. (a) PRINT FULL NAME Henry H. Brockman

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Lena Brockman 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 20, 1855  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	85	2	6	_____ hr. _____ min.

9. Birthplace Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired merchant

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Brockman

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name William Brock

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

16. (a) Informant's own signature Susan A. Shaw

(b) Address 2609 S. Grand

17. (a) Burial (b) Date thereof Mar. 28, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mathews Cemetery

18. (a) Signature of funeral director Craig Mortuary

(b) Address 4468 Washington Blvd.

19. (a) MAR 28 1940 (b) J. F. [Signature]  
(Date received local registrar) (Embalmer's signature)

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.

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**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

*Philip M. Henry*

Licensed Embalmer No. 3281

P. O. Address 4468 Washington Blvd.

**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.**