

MAY 15 1940

791

1003

State File No.

Registrar's No.

3100

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (c) Name of hospital or institution: St. Charles Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3  
 (Specify whether 3)  
 In this community 625  
 years, months or days

3. (a) PRINT FULL NAME AUGUST H. BRAKENSIEK

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 MARRIED

6. (b) Name of husband or wife Carrie Brakensiek 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased. Oct 2 1878  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>62</u>	<u>6</u>	<u>0</u>	<u>0</u>	hr. min.

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

10. Usual occupation Clerk

11. Industry or business 6

MOTHER FATHER { 12. Name August Brakensiek 6

13. Birthplace Germany 6  
 (City, town, or county) (State or foreign country)

14. Maiden name Saur

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

16. (a) Informant Barrie Brakensiek

(b) Address 1430 Chamber str

17. (a) Burial (b) Date thereof April 5, 40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Peter

18. (a) Signature of funeral director Central Wnd. Co

(b) Address 1841 Cass ave

19. (a) APR 3 1940 (b) J. Brakensiek  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County \_\_\_\_\_  
 (c) City or town St Louis 26  
 (If outside city or town limit, write "RURAL")  
 (d) Street No. 1430 Chamber str  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 40 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd  
 year 1940 hour 16:00 minute 0 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 \_\_\_\_\_

Primary Sclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Arterio Sclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 946

Duration

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) \_\_\_\_\_ (Specify means of injury)

23. Signature Robert Perry (M. D. or other) 5

Address 4011 Pine Date signed 4-3-40

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

**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

*Albert W. Happe*

Licensed Embalmer No. 1861

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.**