

No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13221

MAY 15 1940
Registration District No. 791

Primary Registration District No. 1003

State File No.
Registrar's No. 3423

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

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Emma R. Broeker

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William Broeker
6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased Nov. 12 - 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 5 3 hr. min.

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

10. Usual occupation Housework

11. Industry or business _____
12. Name Christina Ruhl
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Sutton
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Wm Broeker
(b) Address 17 S. Bemiston, Clayton MO

17. (a) Burial (b) Date thereof 14-17-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Elm Lawn Cem.

18. (a) Signature of funeral director Louis H Ropp
(b) Address Kirkwood, Mo

19. (a) APR 15 1940
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Clayton NR
(If outside city or town limits, write "RURAL")
(d) Street No. 17 S Bemiston
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15
year 1940 hour 7 minute 17 M.

21. I hereby certify that I attended the deceased from Sept. 25, 1939 to April 15, 1940
that I last saw her alive on April 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory failure
Duration 24 hrs.

Due to Lung abscess, chronic interstitial Nephritis with hypertension.
Due to caused by staphylococcus

Other conditions septicemia
(Include pregnancy within 5 months of death)

Major findings: Of operations _____
Of autopsy As above. 131
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 Louis H Ropp (M. D. or other) _____
Address 885 Univ. Club Bldg. Date signed 4-15-40

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 _____

Norris H. Bogg

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Norris H. Bogg

Licensed Embalmer No. *921*

P. O. Address *Kirkwood*

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.