

Registration District No.

791

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Louis Children's Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 days
(Specify whether
In this community _____
years, months or days) 652

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County _____
(c) City or town Peoria NR
(If outside city or town limits, write "RURAL")
(d) Street No. 521 Greenlawn
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Paul Edw Brandenburg

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased 9 - 36
(Month) (Day) (Year)

8. AGE: Years 3 Months 9 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Chief

11. Industry or business _____

12. Name Arthur

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

14. Maiden name Laverne Smutzer

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

16. (a) Informant F. Harpeth

(b) Address 500 S. Kingsleyway

17. (a) Removal (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Graveside

18. (a) Signature of funeral director Albert H. Hoff

(b) Address 4700 Washington St

19. (a) JUN 20 1940 (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6th day 28th year 1940 hour 8th minute 15 P.M.

21. I hereby certify that I attended the deceased from 5-29-1940 to 6-28-40 that I last saw him alive on 6-28-1940 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Tumor of the fourth ventricle of brain
Due to Malignant

Due to 53

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

Major findings: Of operations as above

Of autopsy as above

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 Henry G. Schwartz (M. D. or other) M.D.

Address 506 S. Waterman Date signed 6-29-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Robert W. Wagner

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.