

FILED APR 3 1943
Registration District No.

Primary Registration District No. **1003**

Registrar's No. **2959**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5mo., 6days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **17**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3842 Washington**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country **American**

3. (a) PRINT FULL NAME **Violet Ida, Brinkman**

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

4. Sex **Female** / Color or race **White**
5. Color or race **White** / 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mr. Emil, Brinkman** 6. (c) Age of husband or wife if alive **35** years
7. Birth date of deceased **September 28 1907**
(Month) (Day) (Year)

8. AGE: Years **35** Months **5** Days **29** If less than one day hr. min.

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

10. Usual occupation **????**

11. Industry or business **None**

12. Name **Guy Erbschloe**

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

14. Maiden name **Ida, Vicker**

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

16. (a) Informant **Louise Green**

(b) Address **5800 Arsenal**

17. (a) **Burial** (b) Date thereof **3-30-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Friedens Cemetery**

18. (a) Signature of funeral director **Cullinane Bros.**

(b) Address **1710 N. Grand Blvd.**

19. (a) **MAR 29 1943** (b) **J. D. Bruders**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **27th**, year **1943** hour **8:35** minute **A.** M.

21. I hereby certify that I attended the deceased from **Jan 15, 1943**, 19 to **Mar 28, 1943**, 19; that I last saw her alive on **Mar 26, 1943**, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: **Cancer of floor of mouth** **Dehydration & Tachesia**
Duration **sev. yrs**

Due to
Due to

Other conditions (Include pregnancy within 3 months of death) **None**

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) (c) Means of injury:

23. Signature **Roy E. Ahrens** (M. D. or other) **5600 Arsenal** Date signed **3/26/43**

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

38.

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.....

Fred Frick

Licensed Embalmer No.....

3186

P.O. Address.....

St. Louis, Mo.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2959

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis, mo
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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) (Specify whether _____) F

3. (a) PRINT FULL NAME Veola Gola Brunkman

3. (b) If veteran, name war _____
3. (c) Social Security No. 992-70-9460

4. Sex _____ race _____
5. Color or _____
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 _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one year _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director William B. B...

(b) Address _____

19. (a) Mar 29 43 (b) J. J. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3842 Washington
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27
year 1943 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

MOTHER FATHER

APR 16 1943

8120