

FILED JUL 17 1943
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis, Mo**
(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: **BARNES HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **66 days** (Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME **Brandt, Dr. Arnold Lewis**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **October 24 1876**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 8 11 hr. min.

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

10. Usual occupation **Physician & Surgeon**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Brandt**

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

14. Maiden name **Margaret Rethorst**

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

16. (a) Informant **Eugenia Hademann**

(b) Address **Warrenton, Missouri**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7/6/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Warrenton, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc**

(b) Address **4700 Washington Blvd.**

19. (a) **JUL 6 1943** (Date received local registrar) **J. J. Budeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Washington** (b) County **King**
(c) City or town **Seattle** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **U**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **5**
year **1943** hour **11** minute **55** P.M.

21. I hereby certify that I attended the deceased from **4-30** 19**43** to **7-5** 19**43**
that I last saw h.i.m. alive on **7-5** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Retroperitoneal hemorrhage**

Due to **rupture of aneurysm of abdominal aorta**

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

Major findings: Of operations _____

Of autopsy **Rupture of aneurysm of abdominal aorta + retroperitoneal hemorrhage**

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. C. Abney** (M. D. or other)

Address **BARNES HOSPITAL** Date signed **7-6-43**

JUL 7 1953

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..... *G. W. Wilkinson*
Licensed Embalmer No..... *3570*

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, fact should be so stated above.