

FILED SEP 21 1943
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4900 St. Louis Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community
years, months or days

3. (a) PRINT FULL NAME Sophie Brockmeier.

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

4. Sex F / Color or race W
6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Herman Brockmeier
6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased February 11th-1869
(Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 1
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Fred Koenemann

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

14. Maiden name Wilhelmina --Unknown.

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

16. (a) Informant Dr. Martin Brockmeier

(b) Address 4900 St. Louis Ave.

17. (a) Burial (b) Date thereof 9-15-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Okawville, Illinois.

18. (a) Signature of funeral director Sullivan Brothers.

(b) Address 2849 North Euclid Ave.,

19. (a) SEP 13 1943 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 4900 St. Louis Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12th
year 1943 hour 2 A.M. minute M.

21. I hereby certify that I attended the deceased from Mar 1 1943 to Sept 12 1943
that I last saw h. r. alive on Mar 11 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis 1 year
Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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) Means of injury

23. Signature C. J. Shepherd (M. D. or other)
Address 1259 W. King St. Kansas Date signed 9-13-43

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

MOTHER FATHER

Dr. C. T. Shepard,
5.22 Page & Kingshighway

No. 7233

10-12
2-4
7-9 PM.

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.....

John Melnar

Registered Apprentice No.....

working under my personal supervision.

Signed *John A. Melnar*

Licensed Embalmer No. *4186*

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.