

S. No. 2
M-2-43
15-17-30
I X35387

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32938**
Registrar's No. **9253**

OCT 27 1943 **318**
Registration District No.

Primary Registration District No. **1003**

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

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 Anthony Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Day** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **HENRY J BRAD.**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **492-01-6768**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **ANNA BRAD** 6. (c) Age of husband or wife if alive **37** years
7. Birth date of deceased **Oct 11 1905**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 **0** **8** hr. min.

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

10. Usual occupation **Shoe Worker**

11. Industry or business _____

MOTHER FATHER { 12. Name **MATHIAS BRAD**
13. Birthplace **Hungary** **4**
(City, town, or county) (State or foreign country)
14. Maiden name **KATE ROSENSCHWEIF**
15. Birthplace **HUNGARY** **4**
(City, town, or county) (State or foreign country)

16. (a) Informant **ANNA BRAD.**
(b) Address **2839 Minnesota Ave.**

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof **OCT 22/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **NEW ST MARCIUS**

18. (a) Signature of funeral director **Thaddeus & Son**
(b) Address **2906 Gravois Ave.**

19. (a) **OCT 21 1943** (Date received local registrar) (b) **J. F. Brebeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **000**
(c) City or town **St Louis** **17**
(If outside city or town limits, write "RURAL") **0/6**
(d) Street No. **2839 Minnesota Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **19**
year **1943** hour **4 03 P.** minute _____ M.
21. I hereby certify that I attended the deceased from **10-26** 19 **35** to **10-19** 19 **43**
that I last saw him alive on **Oct 19** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis**
E. mitral stenosis - Rheumatic
Chronic infarctio
Duration **20 yrs.**
since

Due to _____

Due to _____

Other conditions **1/31**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **none**
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) **no**

(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 **W. J. Williams** (M. D. or other) _____

Address **3809 Wilming St. Apr 16.** Date signed **10-20-43**

3806 Williamson
7

7. 8.30

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed *David Van Fossan.*

Licensed Embalmer No. *4242*

P. O. Address *2906 Harrison*

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.