

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **109**  
Registrar's No. **851**

LED FEB 4 1944

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Infant Brink.

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 0  
6. (b) Name of husband or wife XXXXXX 6. (c) Age of husband or wife if alive XXXX years  
7. Birth date of deceased January 26 1944  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 8 hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Lloyd Brink  
13. Birthplace St. Louis, Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Cecelia Melton.  
15. Birthplace Illinois.  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. C. Brink.  
(b) Address 6312 Derby Avenue.

17. (a) Burial Lakewood Park Cem. (b) Date thereof 1/27/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.  
(b) Address 5966 Easton Avenue

19. (a) JAN 27 1944 (b) F. Brueck  
(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. 5940 A Wabada Avenue. (If rural, give location)  
(e) Citizen of foreign country? Yes. (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26  
year 1944 hour 3:30 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 26 1944 to Jan 26 1944  
that I last saw him alive on Jan 26 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

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? \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]  
Address 1589 E. Pilgrimage Date signed 1-26-44

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

Dr L. A. Hayden.  
5899 Delmar Avenue.

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**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

*Ben Hoffman*

Licensed Embalmer No. *4366*

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.