

V. S. No. 2
 FORM-5-43
 Rev. 5-17-39
 I X36671

8749

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 20 1944
 Registration District No. _____

318

Primary Registration District No. 1003

Registrar's No. 2249

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:
Christian Hoapital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
 (Specify whether _____)
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 12
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL") 9/0
 (d) Street No. 4203 College Ave.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Katharine Bracke
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 6th
 year 1944 hour 4 minute 15 A.M.

4. Sex Female 5. Color or race Wh
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife John Bracke
 6. (c) Age of husband or wife if alive 63 years
 7. Birth date of deceased March 13 1882
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 28
 1944 to March 6 1944
 that I last saw her alive on March 5 1944
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
61 11 22 _____ hr. _____ min.

Immediate cause of death Peritonitis Duration 2 days

9. Birthplace Germany (City, town, or county) (State or foreign country) 4

Due to strangulated femoral hernia 4 days

10. Usual occupation Housewife

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

11. Industry or business _____

Major findings: Strangulated femoral hernia, necrosis of intestine
 Of operations _____
 Of autopsy Same as above plus sutures failed to hold intestinal resection
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Carl Schieber
 13. Birthplace Germany (City, town, or county) (State or foreign country) 4

14. Maiden name Rosina Blank (City, town, or county) (State or foreign country) 4
 15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant John Bracke (Husband)
 (b) Address 4203 College Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-44 (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Kraeger-Voss-Fix
 (b) Address 3402 No. Kingshighway

19. (a) MAR 7 1944 (Date received local registrar)
 (b) J. F. Bredeek (Registrar's signature)

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 Eugene J. Arnold (M. D. or other) MD
 Address 1449 M^c Laran Date signed _____

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

844

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.