

FILED JAN 15 1948

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 11214

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:
8636 S Broadway
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME ANTON BRAND

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

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

6. (b) Name of husband or wife FRANCES BRAND 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased About 1874
(Month) (Day) (Year)

8. AGE: Years About 70 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Frances Brand
 (b) Address 8636 S Broadway

17. (a) Burial (b) Date thereof Dec 29/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old S. S. Peter & Paul

18. (a) Signature of funeral director Thorshutes & Son

(b) Address 2906 Gravois Ave

19. (a) DEC 29 1944 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 8636 S Broadway
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23rd
 year 1944 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

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?
(Specify type of place)

While at work _____ (Specify type of place) _____
(or) Means of injury _____

23. Signature Patrick E. Jugh (M.D. or other) _____

Address dep - Cor Date signed 12/29/44

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

2016
17
9

Cerebral Apoplexy
82a

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Horn*

Licensed Embalmer No. *4242*

P. O. Address *2906 Harris*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan*

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's No. *11214*

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

3. (a) PRINT FULL NAME *Arthur Brand*
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex *M* 5. Color or race *W*
 6. (a) Single, widowed, married, divorced *M*
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased *about*
(Month) (Day) (Year)

8. AGE: Years Months Days *70*
If less than one day min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
 { 12. Name.....
 { 13. Birthplace.....
(City, town, or county) (State or foreign country)
 { 14. Maiden name.....
 { 15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) *JAN 19 1945* (b) *J. F. Bredek*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State..... (b) County.....
 (c) City or town.....
(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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....
 that I last saw him..... alive on....., 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

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)
 (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

39185