

FILED JAN 11 1948
318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 10367

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:
2031 OBEAR AVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NIL
(Specify whether
In this community 64 YRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County
(c) City or town ST. LOUIS 917
(If outside city or town limits, write "RURAL")
(d) Street No. 2031 OBEAR AVE 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME AMELIA BRINKMEYER

3. (b) If veteran, name war NIL 3. (c) Social Security No. 333-03-3910

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased SEP. 10 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 3 5 hr. min.

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

10. Usual occupation SUPERVISOR

11. Industry or business NATH. ENAMELING Co

12. Name W^m BRINKMEYER

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

14. Maiden name MARY HECHTRECK

15. Birthplace ST. LOUIS Mo
(City, town, or county) (State or foreign country)

16. (a) Informant ELIZABETH BRINKMEYER

(b) Address 2031 OBEAR AVE

17. (a) BURIAL (b) Date thereof 12/18/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. PETERS CEM

18. (c) Signature of funeral director Quedmeyer

(b) Address 3924 1945 St.

19. (a) DEC 17 1945 (b) J. J. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15
year 1945 hour 11 minute 02 A. M.

21. I hereby certify that I attended the deceased from N.V. 1949 to Jan 15 1948
that I last saw her alive on 12/15/45 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage Duration 1 day

Due to arterial Hypertension

Due to Heart & Blood

Other conditions History - Chronic
(Include pregnancy within 3 months of death)

Major findings: Of operations 82

Of autopsy 82

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) (c) Means of injury

23. Signature J. O. Puler (M. D. or other)

Address 2465 W. T. ... Date signed 12-17-45

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

MOTHER FATHER

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.....

..... Registered Apprentice No.

working under my personal supervision.

Signed... *Benneth W. Jones*

Licensed Embalmer No. *4224*

P. O. Address *3423 Lane*

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.