

No. 2
M-5-43
5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18215**
Registrar's No. **4458**

FILED MAY 31 1946
Registration District No. **398**

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
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4155 Blow
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 72 years
years, months or days

3. (a) PRINT FULL NAME Mrs. Catherine J. L. Brockmeier

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

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Henry W. Brockmeier 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 31, 1873
(Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 16
If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Edward Struve

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

14. Maiden name Unknown

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

16. (a) Informant Norman Brockmeier

(b) Address 1280 Boland Place

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20, 1946
(Month) (Day) (Year)

(c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director Beiderwieden Funeral H., Inc.

(b) Address 1936 St. Louis Avenue

19. (a) MAY 18 1946 (Date received local registrar) J. F. Medeck (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") 9/14

(d) Street No. 4155 Blow Avenue
(If rural, give location) 9

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17, year 1946 hour 7: minute 40 A. M.

21. I hereby certify that I attended the deceased from May 11 1946, to May 15 1946; that I last saw him alive on May 11 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis - chronic Duration 8 yrs.

Due to coronary thrombosis? 1 week

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? _____

23. Signature Karl J. Balazs M.D. (M. D. or other) 0
Address 86230 Cleveland Ave Date signed 5/15/46

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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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed *Glen W. Holt*

Licensed Embalmer No. *3737*

P. O. Address. *1936 St. Louis Ave.*

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.