

No. 2  
-2-43  
17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28279 ✓

State File No. ....

**FILED** AUG 20 1946

Registration District No. 3

Primary Registration District No. 6076

Registrar's No. 1698

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town Pinelawn, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
7013 Lexington Ave.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 In this community.....  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County 96  
 (c) City or town Pinelawn, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 7013 Lexington Ave.  
 (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME Lena Brend  
 3. (b) If veteran, name war No 3. (c) Social Security No. No

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 14th  
 year 1946 hour 10 minute A M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Henry 6. (c) Age of husband or wife if alive..... years  
 7. Birth date of deceased March 31st, 1867  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from August 7, 1946 to August 13, 1946  
 that I last saw her alive on 8-13 and that death occurred on the date and hour stated above.

8. AGE: Years 79 Months 4 Days 15 If less than one day  
 hr. min.

Immediate cause of death Coronary heart failure  
 Due to myocardial disease

9. Birthplace Warrenton, Mo. (City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife

Other conditions Fracture tibia  
 (Include pregnancy within 3 months of death)  
at home 8-20-46

11. Industry or business.....  
 12. Name William Hoecker  
 13. Birthplace Germany (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace..... (City, town, or county) (State or foreign country)

Major findings:  
 Of operations.....  
 Of autopsy.....  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Ben Brand  
 (b) Address 7013 Lexington Ave.  
 17. (a) Burial (b) Date thereof 8/17th/46  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St. Peters Kraeger-Voss  
 18. (a) Signature of funeral director St. Peters Kraeger-Voss  
 (b) Address 3402 N. Kingshighway  
 19. (a) 8-16-46 (b) E. J. McArthur  
 (Data received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) 96  
 (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 9  
 23. Signature 24 - J. J. Feller (M. D. or other) M.D.  
 Address 2807 N. Grand Date signed 8-15-46

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

**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..... *S. W. Wilkinson*.....

Licensed Embalmer No..... *3575*.....

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.

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Pineblow  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Lena Brand

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased mar 31  
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 0 (Unless than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

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 \_\_\_\_\_

(a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

(a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Data 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 \_\_\_\_\_ year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Fracture neck  
Of operations: humers

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: product

(a) Accident, suicide, or homicide (specify) August 1 1946

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? St Louis County Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
home

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury fall

23. Signature St J. Fuller (M. D. or other) MD

Address St Louis Mo Date signed 9/30

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

SUPPLEMENTARY

MOTHER FATHER

89178

28279