

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

DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2278**
Registrar's No. **540**

Registration District No. **318**

Primary Registration District No. **1003**

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: Little Sisters of the Poor
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 month 25
(Specify whether years, months or days)

In this community 89 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2209 Hebert Street
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME MATHILDA BRAUN

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 16th
year 1947 hour 11 minute 45 A. M.

21. I hereby certify that I attended the deceased from January 2, 1947 to January 16, 1947
that I last saw her alive on January 15, 1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Theodore Braun

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 20, 1857
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis
Acute upper respiratory infection

Duration ???
3 days

8. AGE: Years 89 Months 2 Days 26
If less than one day _____ hr. _____ min.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

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

10. Usual occupation Nil.

Major findings: Of operations None

Of autopsy None

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 11. Industry or business _____

12. Name Joseph Apprederis

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

14. Maiden name Miller

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

16. (a) Informant Julius Braun

(b) Address 5701 Floy Avenue

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(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? _____

17. (a) Burial (b) Date thereof 1-18-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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

(b) Address 2117 East Grand Blvd.

19. (a) JAN 17 1947 (b) J. F. Bredack
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Nature of injury D

23. Signature [Signature] (M. D. or other) _____

Address 2302 Voluntary St Date signed 1-16-47

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 Frank A. Moore
Licensed Embalmer No. 3041
P. O. Address 2117 E. Grand

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.