

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

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** AUG 15 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. **25349**  
Registrar's No. **7312**

Registration District No. **318** Primary Registration District No. \_\_\_\_\_

**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: **3689a Olive St.** /  
(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

**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")

(d) Street No. **3689a Olive St.** /  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) **9**  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Nona E. Brockman**

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 **married**

6. (b) Name of husband or wife **Francis E. Brockman** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **22 August 13, 1895**  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<b>51</b>	<b>10</b>	<b>20</b>	hr. _____ min. _____

9. Birthplace \_\_\_\_\_ **Iowa** /  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

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

12. Name **Unknown Devere** /

13. Birthplace **Unknown** /  
(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 **Mr. Francis E. Brockman**

(b) Address **3689a Olive St.**

17. (a) **burial** (b) Date thereof **8/6/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Drehmann-Harral**

(b) Address **1905 Union Blvd.**

19. (a) **AUG 5 1947** (b) **J. F. Brockman**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month **August** day **3**  
year **1947** hour **9:20** minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from **Feb 24th 1947** to **Aug 3 - 1947**  
that I last saw h. **alive on Aug 3** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Interstitial nephritis**

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? \_\_\_\_\_

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

23. Signature **Paul Vinyard** M. D. or other **MD**

Address **3718A Olive St.** Date signed **8-5-47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Albert R. Thompson  
Licensed Embalmer No. 4237  
P. O. Address St. Louis

**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.**