

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41308**
Registrar's No. **11257**

FILED JAN 11 1949

Registration District No. **818**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **ST. LOUIS, MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Infirmiry Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6-17-48 to 12-19-48**
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County _____
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **STAG HOTEL 5a W. 9th St**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Joseph Brinkhouse**
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **19**
year **1948** hour **8** minute **15A** M.

4. Sex **MALE** () 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **SINGLE**
(b) Name of husband or wife _____ (c) Age of husband or wife if _____
alive _____ years
7. Birth date of deceased **MARCH 19 1870**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 7, 1948** 19. to **Dec. 19** 19. **48**
that I last saw him alive on **Dec. 19** 19. **48**
and that death occurred on the date and hour stated above.

8. AGE: Years **78** Months **9** Days **0**
If less than one day _____
hr. _____ min. _____

Immediate cause of death
**Arteriosclerotic Heart Disease
& calcification of valves**
Due to _____
Due to **7:30**
Other conditions **Cerebral thrombosis**
(Include pregnancy within 3 months of death)

9. Birthplace **ST. LOUIS MO**
(City, town, or county) (State or foreign country)
10. Usual occupation **ODD JOBS.**

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

11. Industry or business _____
12. Name **BEN BRINKHAUSE**
13. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)
14. Maiden name **BERTHA O.K.**
15. Birthplace **O.K.**
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant **MARGARET KELLY**
(b) Address **2331 MULLANPHY**
17. (a) **BURIAL** (b) Date thereof **12-29-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **CALVARY**

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature **C. J. Krag M.D.** (M. D. or other) _____
Address **5600 Arsenal St St Louis** Date signed **Dec 20 1948**

18. (a) Signature of funeral director **Gallen-Kelly**
(b) Address **4386 Grand St**
19. (a) **DEC 28 1948** (b) **J. B. Lascater**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Emb separate cert filed

DEC 28 1948

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.....

Licensed Embalmer No.....

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.