

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

**FILED JAN 24 1949**

Registration District No. **377**

Primary Registration District No. **6076**

Registrar's No. **2944**

**1. PLACE OF DEATH:**

(a) County St. Louis

(b) City or town Koch, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Robert Koch Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days  
(Specify whether)

In this community life  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

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

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

(d) Street No. 1262 W. Kings Highway  
(If rural, give location)

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

**3: (a) PRINT FULL NAME** BRAUN, FRED

3. (b) If veteran, name war no

3. (c) Social Security No. 488-03-2159

4. Sex M Color or race W

5. Color or race W

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

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

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased 9-7-92  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 12 day 21  
year 1948 hour 6 minute 20 A.M.

21. I hereby certify that I attended the deceased from 11-30-48  
\_\_\_\_\_ 19\_\_\_\_, to 12-21 1948  
that I last saw h. alive on 12-21 1948  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>56</u>	<u>3</u>	<u>14</u>	hr. _____ min. _____

Immediate cause of death Chronic Pulmonary Tuberculosis **Duration** ???

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

Due to 136

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

10. Usual occupation Carpenter

Other conditions Laryngeal Tuberculosis  
(Include pregnancy within 9 months of death)

MOTHER FATHER

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

12. Name Peter Braun

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

14. Maiden name Mary Kabele

15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy CO 2 X

**PHYSICIAN**  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Hospital Records, Robert Koch

(b) Address Koch Hospital, Koch, Mo.

17. (a) Burial (b) Date thereof 12-23-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Sam Miller

(b) Address 5041 Alhambra Blvd

19. (a) 12-23-48 (b) Frederic V. Jung  
(Date received local registrar) (Registrar's signature)

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 John Niedermayer (M. D. or other) MD.  
Address Koch, Mo. Date signed 12-21-48

**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 John M. Sigmore  
Licensed Embalmer No. 4343  
P. O. Address St. Louis Mo.

**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.**