

FILED MAR 8 1949

STANDARD CERTIFICATE OF DEATH

State File No. 6968
03242

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gardenville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gardenville	
c. LENGTH OF STAY (in this place) 4 MO.		d. STREET ADDRESS (If rural, give location) Miller Nursing Home	
d. FULL NAME OF HOSPITAL OR INSTITUTION Miller Nursing Home		4. DATE OF DEATH (Month) (Day) (Year) 2/9/49	

3. NAME OF DECEASED (Type or Print) Otto		a. (First) Otto		b. (Middle) E.		c. (Last) Brightfield		4. DATE OF DEATH (Month) (Day) (Year) 2/9/49	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH May 27, 1859		9. AGE (In years last birthday) 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME Charles Brightfield		13b. MOTHER'S MAIDEN NAME Theresa Fruth		14. NAME OF HUSBAND OR WIFE Theresa F.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lester H. Heinecke--4152 Hartford	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility, Perinial Hypostatic Pneumonia					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 493X					
		DUE TO (c) 493X					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) ho		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Jan, 1949, to Feb-9, 1949, that I last saw the deceased alive on Feb-9, 1949, and that death occurred at 7:00 A. m., from the causes and on the date stated above.

23a. SIGNATURE R. Berg MD.		(Degree or title) 0		23b. ADDRESS 3203 S Grand City		23c. DATE SIGNED 2-10-49	
24a. BURIAL CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/12/49		24c. NAME OF CEMETERY OR CREMATORY Walnut Hill Cemetery		24d. LOCATION (City, town, or county) (State) Belleville, Ill.	

DATE REC'D BY LOCAL REG. 2/10/49		REGISTRAR'S SIGNATURE Theresia Pennington MD		25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Welderle		ADDRESS 3634 Gravois	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

96000

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Delid J. Krupin

Licensed Embalmer No. 3497

P. O. Address 8634 Gravois

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.