

300
48

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9843**
2687
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4419 Clarence Ave.		d. STREET ADDRESS (If rural, give location) 4419 Clarence Ave.	

3. NAME OF DECEASED (Type or Print) Josephine R. Brockrieten			4. DATE OF DEATH (Month) (Day) (Year) March 22 1949		
a. (First)	b. (Middle)	c. (Last)			

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 12, 1867	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 4	IF UNDER 1 MIN. Hours 	IF UNDER 1 MIN. Min.
----------------------	-------------------------------	---	---------------------------------------	---	---------------------------------	--------------------------------	-------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	-----------------------------------	--	---

13a. FATHER'S NAME Henry Moeller	13b. MOTHER'S MAIDEN NAME Mary Robus	14. NAME OF HUSBAND OR WIFE (Dec.) Joseph A Brockrieten
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Miss Marie Brockrieten/Clarence	4419 ADDRESS
---	-------------------------------------	--	--------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis		DUE TO (b) Arteriosclerosis		3 1/2
ANTECEDENT CAUSES		DUE TO (c)		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				
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 checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	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)	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 **Dec 18, 1949**, to **March 22, 1949**, that I last saw the deceased alive on **March 21, 1949**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE J. B. Pasater (Degree or title)	23b. ADDRESS 539 N. Grand	23c. DATE SIGNED 3-24-49
---	----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 26 1949	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
---	-------------------------------	--	--

DATE RECD. BY LOCAL REGISTRAR'S SIGNATURE J. B. Pasater	25. FUNERAL DIRECTOR'S SIGNATURE Bromschwig and Son ADDRESS 746 W. Florissant
--	---

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

J. W. Wilkinson

Signed _____

Student Embalmer

Licensed Embalmer No. _____

35765

P. O. Address _____

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.