

FILED MAY 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18053

No. 300
10-48

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6876 Registrar's No. 823

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) a. STATE Missouri b. COUNTY 000	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Ozark Nursing Home		d. STREET ADDRESS (If rural, give location) 275I Queens St.	

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) L. c. (Last) Bracking			4. DATE OF DEATH (Month) (Day) (Year) 4/7/49		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 79?	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Detroit, Michigan		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME ? Schulthies	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE William Bracking
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Harold Bracking ADDRESS 275I Queens St.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH:(a) Coronary atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) unknown 4201		
	DUE TO (c) unknown		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None 94a			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12 March, 1949**, to **7 April, 1949**, that I last saw the deceased alive on **6 April, 1949**, and that death occurred at **10:55 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE J. A. Barnett M.D. (Degree or title)	23b. ADDRESS 243 W. Jefferson, Kirkwood	23c. DATE SIGNED 4-8-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/9/49	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County
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DATE REC'D BY LOCAL REG. 8-8-49	REGISTRAR'S SIGNATURE Harold Bracking	25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Funeral Dir. ADDRESS 2849N. Euclid
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Dr. J.H. Barnett

243 West Jefferson, Kirkwood

Terryhill 3-0944

2⁰⁰ to 4⁰⁰ pm Friday

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 _____

working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed *Robert L. Brinkman*
Licensed Embalmer No. 3653

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.