

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27887
State File No. 7331

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>100</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) township) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		17			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>4565 Wichita Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>4565 Wichita Ave.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>BRIDGET</u>		b. (Middle) <u>E.</u>		c. (Last) <u>BRADY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 22 1949</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Nov. 11, 1863</u>			
9. AGE (In years last birthday) <u>85</u>		10. IF UNDER 1 YEAR Month <u>9</u> Days <u>11</u> Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <u>Washington, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			
13c. NAME OF HUSBAND OR WIFE <u>Late Thomas Brady</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Edna Brady 4565 Wichita Ave.</u>			
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Mixed infection of the bronchae</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Ununited fracture left femur 2 yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Five days or more</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <u>4565 Wichita Ave. St. Louis Mo.</u>		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 <u>4 2 2 9</u>		22. I hereby certify that I attended the deceased from <u>Aug 18, 1948</u> to <u>Aug 22, 1949</u> , that I last saw the deceased alive on <u>Aug 21, 1949</u> , and that death occurred at <u>8:45 Am.</u> , from the causes and on the date stated above.				23a. SIGNATURE (Degree or title) <u>Paul McRae D.D.</u>			
23b. ADDRESS <u>5023 Washington Blvd.</u>		23c. DATE SIGNED <u>8/22/49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 25, 1949</u>			
24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>AUG 23 1949 J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser 4228 S. Kingshighway Bl.</u>			

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.

Student
Student Embalmer

Signed *Edwin A. M. Heruatt*

Licensed Embalmer No. 3024

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.