

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6037
State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1604**

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 town or TOWN St. Louis)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 3655a Montana Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3655a Montana			

3. NAME OF DECEASED (Type or Print) a. (First) Fred b. (Middle) A. c. (Last) Brockmeier		4. DATE OF DEATH (Month) (Day) (Year) 2/16/50	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 18, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pattern Maker		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 Brockmeier		13b. MOTHER'S MAIDEN NAME Christina Meyer		14. NAME OF HUSBAND OR WIFE Josephine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Josephine Brockmeier--3655a Montana	

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) Metastatic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 4/18/48	
ANCECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) of Lymphoid Bone			
		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION 7/27/48		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Lymphoid -		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) 158X	
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?	

22. I hereby certify that I attended the deceased from **6/28/1948**, to **2/16/1950**, that I last saw the deceased alive on **2/16/1950**, and that death occurred at **8:30p m.**, from the causes and on the date stated above.

23a. SIGNATURE J. C. Hasenbury MD (Degree or title)		23b. ADDRESS 3606 Francis		23c. DATE SIGNED 2/17/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/20/50		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	
		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri			
DATE REC'D BY LOCAL REG. FEB 18 1950		REGISTRAR'S SIGNATURE J. C. Hasenbury		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Welder 3634 Gravois	

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

661 27 1952

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.....

Signed.....
Student Embalmer

Signed *Delia J. Krissin*

Licensed Embalmer No. *3497*

P. O. Address *3634 Hawaii*

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.