

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 22 1950
#112596

State File No. 31552

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No. 7206

1. PLACE OF DEATH a. COUNTY		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 St. Louis, Missouri.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 24 3620 S. Jefferson 0	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) ELIZABETH	b. (Middle) BREMERKAMP	c. (Last)	Sept. 8th, 1950		

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 12, 1869	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months 6	IF UNDER 1 YEAR Days 26	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) St. Charles, Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Carl Dutcher	13b. MOTHER'S MAIDEN NAME Amelia Becker	14. NAME OF HUSBAND OR WIFE John Bremerkamp
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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 Walter Bremerkamp, East St. Louis, Ill.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Hodgkins Disease</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <i>Many years</i>
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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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>201X</i>
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22. I hereby certify that I attended the deceased from 6/26/50, 19__, to 9/8/50, 19__, that I last saw the deceased alive on 9/8/50, 19__, and that death occurred at 10am m., from the causes and on the date stated above.

23a. SIGNATURE <i>John L. Bryan M.D.</i> (Degree or title)	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 9/8/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 12, 1950	24c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	24d. LOCATION (City, town, or county) (State) St. Charles, Mo.
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DATE REC'D BY LOCAL REG. SEP 12 1950	REGISTRAR'S SIGNATURE <i>J. R. Kauter</i>	FUNERAL DIRECTOR'S SIGNATURE <i>W. H. ...</i> ADDRESS <i>St. Charles Mo.</i>
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

[Handwritten Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. *3155*

P. O. Address *[Handwritten 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.