

FILED MAR 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH 1003

State File No. 9915

318

1591

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		Registrar's No. 1591	
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 Mo		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2239		d. STREET ADDRESS (If rural, give location) 1426 1/2 S. BROADWAY	
d. FULL NAME OF HOSPITAL OR INSTITUTION PEACONESS HOSPITAL				3. NAME OF DECEASED a. (First) STASIA b. (Middle) - c. (Last) BRANDT			
4. DATE OF DEATH (Month) (Day) (Year) FEB. 14 1951		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH FEB. 22 1880		9. AGE (In years last birthday) 70		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME PATRICK RYAN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE HENRY BRANDT (DECEASED)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME JOHN KANE ADDRESS 1426 1/2 S. BROADWAY	
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) Carcinoma of rectum INTERVAL BETWEEN ONSET AND DEATH 2 years ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 _____		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) _____			
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? 154X			
22. I hereby certify that I attended the deceased from 12-1-1947 to 7/14/1951 , that I last saw the deceased alive on 7/17/1951 , and that death occurred at 1 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE [Signature] Mueller (Degree or title) _____		23b. ADDRESS 975 Acadia Bldg		23c. DATE SIGNED 7/16/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE FEB. 17 1951		24c. NAME OF CEMETERY OR CREMATORY SANDUSKY OHIO			
24d. LOCATION (City, town, or county) (State) _____		DATE REC'D BY LOCAL REG. FEB 16 1951		REGISTRAR'S SIGNATURE [Signature]			
25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutei ADDRESS 2906 Garrison							

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

[Handwritten scribble]

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 _____

Leo J. Budde

Signed

Student Embalmer

Licensed Embalmer No. _____

3989

P. O. Address _____

St. Louis, Mo

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.