

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **2615**  
Registrar's No. **0316**

BIRTH NO. **FILED FEB 5 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis,</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>Clayton</b> <b>445 P</b>	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>615 Forest Court.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>MILTON</b>	b. (Middle) <b>DAVID</b>	c. (Last) <b>BRESCHELL</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>January 12, 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jul. 8, 1897.</b>	9. AGE (In years last birthday) <b>56.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Refrigeration Co.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Refrigeration</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Milwaukee, Wisconsin</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Maurice Breschell</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Bernstein</b>	14. NAME OF HUSBAND OR WIFE <b>Faye Breschell</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>W.W. 1 493-03-6026</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Faye Breschell</b>	ADDRESS <b>615 Forest Court.</b>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Massive intra-cerebral hemorrhage with secondary bleeding in subarachnoid space</b>		<b>8 hours</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular Disease</b>		<b>Sev. yrs.</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 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)
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? <b>443 X</b>

22. I hereby certify that I attended the deceased from 1-11, 1954, to 1-12, 1954, that I last saw the deceased alive on 1-12, 1954, and that death occurred at 1:25 A.M., from the causes and on the date stated above.

23a. SIGNATURE <b>H. P. Madala</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>1-12-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>1-14-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mount Sinia Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>JAN 12 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	2. FUNERAL DIRECTOR'S SIGNATURE <b>Mayer Fun. Home</b>	ADDRESS <b>4356 Lindell Blvd.</b>
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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *G. W. Wilkinson*

Licensed Embalmer No. *3*

P. O. Address *W. L.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.