

FILED AUG 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24294**  
Registrar's No. **6637**

BIRTH NO. 46435-54 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 <u>MISSOURI</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>HOUSE SPRINGS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>22 ST. LOUIS MATERNITY HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>R.R. # 2</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>INFANT</u> b. (Middle) <u>FEMALE</u> c. (Last) <u>BRACKMANN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7-18-54</u>		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH <u>7-17-54</u>		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>ROY V. BRACKMANN</u>	
14. MOTHER'S MAIDEN NAME <u>ANTIONETTE ELIZABETH SCHUMACK</u>		15. NAME OF HUSBAND OR WIFE <u>NONE</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
17. SOCIAL SECURITY NO.		18. INFORMANT'S SIGNATURE OR NAME <u>ST. LOUIS MATERNITY, 630 SO. KINGSHIGHWAY</u>		19. ADDRESS	

15a. FATHER'S NAME		15b. MOTHER'S MAIDEN NAME		15c. NAME OF HUSBAND OR WIFE	
<u>ROY V. BRACKMANN</u>		<u>ANTIONETTE ELIZABETH SCHUMACK</u>		<u>NONE</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>Chloelasis secondary to prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" type="checkbox"/> NO <input 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? <u>7625</u>	

22. I hereby certify that I attended the deceased from 7-17-54, 1954, to 7-18-54, 1954, that I last saw the deceased alive on 7-18-54, 1954, and that death occurred at 2:45A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Head Boles M.D.</u>		23b. ADDRESS <u>630 So. Kingshighway</u>		23c. DATE SIGNED <u>7/18</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/19/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Rock Creek</u> <u>Mo</u>	
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DATE REC'D BY LOCAL REG. <u>JUL 19 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brunner Funeral Home</u>		ADDRESS <u>Home Springs</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

*No Embalmer*

Licensed Embalmer No. ....

P. O. Address

*1104 March*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.