

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31647

FILED SEP 21 1954

State File No. ....

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 8141

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8501 Drury Lane		e. STREET ADDRESS (If rural, give location) 8501 Drury Lane 20870	
3. NAME OF DECEASED (Type or Print) a. (First) Emilia b. (Middle) c. (Last) Breier		4. DATE OF DEATH (Month) (Day) (Year) 9 2 1954	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-4-1900
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. BIRTHPLACE (City and State or Foreign Country) Austria
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Own home	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Frank Meyer		13b. MOTHER'S MAIDEN NAME Maria Kreiner	14. NAME OF HUSBAND OR WIFE Julius Breier Sr.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 494-34-0487	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Julius Breier Sr. 8501 Drury Lane
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) Giant Follicle Lymphoma  INTERVAL BETWEEN ONSET AND DEATH 2 yrs.  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 Biopsy showed Giant follicle lymphoma.	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 2020			
22. I hereby certify that I attended the deceased from 3-1, 1954 to 9-2, 1954, that I last saw the deceased alive on 8-2, 1954, and that death occurred at 7:45 p.m., from the causes and on the date stated above.			
23a. SIGNATURE C. J. ...		23b. ADDRESS C. J. ...	
23c. DATE SIGNED 9-3-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-6-1954	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REG. SEP 3 1954		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward Koch & Son - 3516 N. 14th	

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

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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 *V E Morris*.....

Licensed Embalmer No. *33*.....

P. O. Address *St Louis*.....

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.