

FILED DEC 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42231

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11150**

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 town) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5204 Alcott Avenue		e. STREET ADDRESS (If rural, give location) 5204 Alcott Avenue 2079	

3. NAME OF DECEASED (Type or Print) a. (First) August b. (Middle) c. (Last) Brumm			4. DATE OF DEATH (Month) (Day) (Year) 12 - 5 - 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 12 - 15 - 1889	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Daniel Brumm	13b. MOTHER'S MAIDEN NAME Sophia Blacher	14. NAME OF HUSBAND OR WIFE
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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. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Samuel Nudelman	ADDRESS 4948 Union Bl.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 PM
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
	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 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? 4222

22. I hereby certify that I attended the deceased from **11-30**, **1954**, to **12-5**, **1954**, that I last saw the deceased alive on **12-4**, **1954**, and that death occurred at **6 PM** m., from the causes and on the date stated above.

23a. SIGNATURE Sw Knopp	(Degree or title) D.O.	23b. ADDRESS 4991 Thrush ave	23c. DATE SIGNED 12/7/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12/8/54	24c. NAME OF CEMETERY OR CREMATORY Hiram Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. DEC 7 1954	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral	ADDRESS 1905 Union Blvd.
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

Dr. G. W. Knapp
4981 Thrush Ave.
Mon. - 2 - 8
Tue. 10 - 12 & 2-4

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.....
Albert R. Thompson

Licensed Embalmer No. *423*

P. O. Address *H. J. ...*

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.