

FILED APR 18 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14035

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3003**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis, Mo.</b>	c. LENGTH OF STAY (In hospital, place) <b>1 Wk</b>	c. CITY OR TOWN <b>St. Charles</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" 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>619 Washington Ave</b> <b>0973</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Nora</b>	b. (Middle) <b>A.</b>	c. (Last) <b>Willbrand</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 1, 1955</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 30 1886</b>
9. AGE (In years last birthday) <b>68</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work performed or given if retired) <b>House-keeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Charles Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Henry H. Bruns</b>	13b. MOTHER'S MAIDEN NAME <b>Marie Moehlenkamp</b>	14. NAME OF HUSBAND OR WIFE <b>Theo. Willbrand</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Theo. Willbrand Jr St Charles Mo</b>

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		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Infarction</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Multiple Pulmonary Infarctions</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4200</b>

22. I hereby certify that I attended the deceased from **Mar. 24, 1955**, to **April 1, 1955**, that I last saw the deceased alive on **April 1, 1955**, and that death occurred at **8:00Am.**, from the causes and on the date stated above.

23a. SIGNATURE <i>C. J. ...</i>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>4/1/55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>April 4 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St Charles Mo</b>

DATE REC'D BY LOCAL REG. <b>APR 4 1955</b>	REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. ...</i>	ADDRESS <b>St. Charles Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 14 1956

JUL 26 1955

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 *Arthur C. Bann* .....

Licensed Embalmer No. *3111*

P. O. Address *A. C. Bann*

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.