

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Marion			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 915 N. Grand, St. Louis, Mo.		c. LENGTH OF STAY (in this place) 13 days		c. CITY OR TOWN Centralia	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.		STREET ADDRESS (If rural, give location) 532 Fayette Street			
3. NAME OF DECEASED (Type or Print) a. (First) CHRIS b. (Middle) E. c. (Last) BRANDHORST			4. DATE OF DEATH (Month) (Day) (Year) May 11, 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 2/9/94		9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY building		11. BIRTHPLACE (City and State or Foreign Country) Ferrin, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Henry Brandhorst		13b. MOTHER'S MAIDEN NAME Anna Blitner	
14. NAME OF HUSBAND OR WIFE Celia Brandhorst		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 347-26-1696	
17. INFORMANT'S SIGNATURE OR NAME VA Hosp. Records, St. Louis, Mo.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES DUE TO (b) Arteriosclerotic Heart Disease		DUE TO (c)	
19. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) VA		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200	
22. I hereby certify that I attended the deceased from 4/28 , 19 55 , to 5/11 , 19 55 , and that death occurred at 6:00 A. m. , from the causes and on the date stated above.					
23a. SIGNATURE J. T. Kaminski		(Degree or title) M.D.		23b. ADDRESS VA Hospital, St. Louis, Mo.	
23c. DATE SIGNED 5/11/55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-11-55	
24c. NAME OF CEMETERY OR CREMATORY Centralia, Ill.		24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Queen-Boggs, Centralia, Ill.	
DATE REC'D BY LOCAL REG. MAY 13 1955		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Queen-Boggs, Centralia, Ill.	

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.....
Ronald O. Yahn

Licensed Embalmer No. *39*
P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.