

FILED NOV 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34607**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9326**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) c. CITY OR TOWN Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) 2027 East Edwards Street.	

3. NAME OF DECEASED (Type or Print)	a. (First) Edward	b. (Middle) J.	c. (Last) Bretz	4. DATE OF DEATH (Month) (Day) (Year) September 17 1955
-------------------------------------	--------------------------	-----------------------	------------------------	----------------------------------------------------------------

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 1883	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Mins. _____
--------------------	-------------------------------	-----------------------------------------------------------------------	----------------------------------	-------------------------------------------	-----------------------------------------	----------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Federal Employee Post-Office	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Springfield, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
-------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------	---------------------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME James Bretz	13b. MOTHER'S MAIDEN NAME Helena Schick	14. NAME OF HUSBAND OR WIFE Mabel Bretz
---------------------------------------	------------------------------------------------	------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. I	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mabel Bretz	ADDRESS 2027 East Edwards St., Springfield, Ill.
----------------------------------------------------------------------------------------------------------------------------	----------------------------------------	------------------------------------------------------	---------------------------------------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1. Internal hemorrhage;		
	ANTECEDENT CAUSES 2. Multiple Fractures; suffered when deceased jumped from window of Division #10 on the 10th floor of City Hospital #1, on the 17th of September, 1955, while suffering a temporary mental aberration.		
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 SUICIDE. E978X	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
------------------------	--------------------------------------------------------	----------------------------------------------------------------------------------

21a. ACCIDENT SUICIDE HOMICIDE (Specify) SUICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hosp	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis - MO
---------------------------------------------------------	------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9-17-55 5:35 p.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR See above
--------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------	--------------------------------------------

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **5:35** p.m., from the causes and on the date stated above.

23a. SIGNATURE James M Kelly (Name or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 10-31-55
-----------------------------------------------------	--------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-31-55	24c. NAME OF CEMETERY OR CREMATORY Galvary Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Illinois
----------------------------------------------------------	---------------------------	------------------------------------------------------------	----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 10-26-55	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Albert J. Happe	ADDRESS 4700 Washington
------------------------------------------	--------------------------------------------	---------------------------------------------------------	--------------------------------

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. 10-29-55 - Reclaimed from the Department of Anatomy, Washington University.

Student.....
Signature of Student Embalmer

Signed... NO EMBALM

Licensed Embalmer No.....

P. O. Address

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.