

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

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 township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. Johns Hosp.		d. STREET ADDRESS (If rural, give location) 1727 N. Union Blvd.	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Ruth c. (Last) Bree			4. DATE OF DEATH (Month) (Day) (Year) May 2, 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec. 25, 1893	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 4 Days 17	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 at home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Michael Bree		13b. MOTHER'S MAIDEN NAME Mary Massett		14. NAME OF HUSBAND OR WIFE none	
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 ADDRESS Wm. Bree 1727 N. Union Blvd.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial failure		DUE TO (b) aortic stenosis			4 mos
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Hypertensive vascular disease			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					known 10 yrs
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 421.1			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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 19, 50, to 5-2, 1956 that I last saw the deceased alive on 5-1, 1956 and that death occurred at 4 a.m., from the causes and on the date stated above.

23a. SIGNATURE A.K. Friskel (Degree or title) M.D.		23b. ADDRESS 18 S. Kingshighway		23c. DATE SIGNED 5-2-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-5-56		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
		24d. LOCATION (City, town, or county) (State) St. Louis Missouri			

DATE REC'D BY LOCAL REG. MAY 3 1956		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas J. Finan 1519 S. Grand Blvd	
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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
Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo.

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 this body is not embalmed, fact should be so stated above.