

FILED MAY 28 1987 CERTIFICATE OF DEATH

DELAYED

124

56-045036

REGISTRATION DISTRICT NO. 077

PRIMARY REGISTRATION DISTRICT NO. 3016

REGISTRAR'S NO.

DO NOT WRITE
ON THIS STUB2
4
5A (Type of Units)7B VS 300
Rev. 1/78

7C

8

10

12

14A

15A

15B

15C & E

15D

21A

24A

25

26

26

26

26

26

26

26

26

27

29A-F

29G-ST

29G-CO

29G-CY

TYPE
OR PRINT
IN
PERMANENT
BLACK
INK
FOR
INSTRUCTIONS
SEE
HANDBOOK

FILED ON THE BASIS OF INFORMATION TAKEN FROM RECORDS OF THE FUNERAL HOME, DOCTOR & HOSPITAL

VS 300
Rev. 1/78

DECEDENT

IF DEATH
OCCURRED IN
INSTITUTION,
SEE HANDBOOK
REGARDING
COMPLETION OF
RESIDENCE ITEMS.

PARENTS

DISPOSITION

CERTIFIER

CONDITIONS
IF ANY
WHICH GAVE
RISE TO
IMMEDIATE
CAUSE
STATING THE
UNDERLYING
CAUSE LASTCAUSE OF
DEATH

DECEDENT—NAME FIRST MIDDLE LAST			SEX	DATE OF DEATH (Mo., Day, Yr.)	
1. Mary Ann Bruemmer			2. female	3. May 2, 1956	
RACE—(e.g., White, Black, American Indian, etc.) (Specify)		AGE—Last Birthday (Yrs.)	UNDER 1 YEAR		DATE OF BIRTH (Mo., Day, Yr.)
4. white		5a. 56	MOS. 5b.	DAYS 5c.	HOURS 5d.
CITY, TOWN OR LOCATION OF DEATH		HOSPITAL OR OTHER INSTITUTION—Name (If not in either, give street and number)			
7b. Jefferson City		7c. St. Marys Hospital			
STATE OF BIRTH (If not in U.S.A., name country)	CITIZEN OF WHAT COUNTRY	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		SURVIVING SPOUSE (If wife, give maiden name)	
8. Missouri	9. U.S.A.	10. married		11. Frank Bruemmer	
SOCIAL SECURITY NUMBER		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY	
13. none		14a. house wife		14b. home	
RESIDENCE—STATE	COUNTY	CITY, TOWN OR LOCATION AND ZIP CODE		STREET AND NUMBER	
15a. Missouri	15b. Cole	15c. Jefferson City		15d. 1729 Lake St.	
INSIDE CITY LIMITS (Specify Yes or No)		15e. yes			
FATHER—NAME FIRST MIDDLE LAST			MOTHER—MAIDEN NAME FIRST MIDDLE LAST		
16. Herman Einhaus			17. Bertha Hoeffer		
INFORMANT—NAME (Type or Print)			MAILING ADDRESS—STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP		
18a. Frank Bruemmer			18b. 1729 Lake St. Jefferson City, Mo.		
BURIAL, CREMATION, REMOVAL, OTHER (Specify)		DATE	CEMETERY OR CREMATORY—NAME		LOCATION CITY OR TOWN STATE
19a. burial		5/5/56	19b. Resurrection		19c. Jefferson City, Mo.
FUNERAL SERVICE LICENSEE Or Person Acting As Such (Signature)		NUMBER	NAME OF FACILITY		ADDRESS OF FACILITY
20a. James E. Grand		1287	20b. Dulle Funeral Home		20c. Jefferson City, Mo.
REGISTRAR		DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)		21b. May 28, 1987	
21a. (Signature) Garland H. Land		22a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.		23a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated.	
(Signature and Title) John Matthews MD		(Signature and Title)		(Signature and Title)	
DATE SIGNED (Mo., Day, Yr.)		HOUR OF DEATH		DATE SIGNED (Mo., Day, Yr.)	
22b. May 22, 1987		22c. 4:25 p. M		23b. DATE SIGNED (Mo., Day, Yr.)	
NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		23c. PRONOUNCED DEAD (Hour)		23d. ON	
22d. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print)		MO. LICENSE NO.		IF HOSP. OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (Specify)	
24a. Jefferson City, MO 65101		24b. 23887		25. Inpatient	
26. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)		INTERVAL BETWEEN ONSET AND DEATH		27. AUTOPSY (Specify Yes or No)	
(a) Ruptured aneurysm anterior communicating artery		29 hours		28. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER (Specify Yes or No)	
(b) Congenital "berry" aneurysm		Congenital		28.	
(c)					
PART II OTHER SIGNIFICANT CONDITIONS—Conditions contributing to death but not related to cause given in PART I (a)		27.		28.	
Cardiomegaly					
ACC. SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)	DATE OF INJURY (Mo., Day, Yr.)	HOUR OF INJURY	DESCRIBE HOW INJURY OCCURRED		
29a.	29b.	29c. M	29d.		
INJURY AT WORK (Specify Yes or No)		PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)	LOCATION (STREET OR R.P.D. NO., CITY OR TOWN, COUNTY, STATE)		IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS
29e.		29f.	29g.		30. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK

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 Sylvester Dulle (DECEASED) by Robert Dulle #5386
512437

Licensed Embalmer No. 4321

P. O. Address Jeff Co. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.