

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14609  
3390

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

FILED APR 26 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Alexian Brothers</b>		e. STREET ADDRESS (If rural, give location) <b>22370 2703 Missouri Ave.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>HENRY</b> b. (Middle) <b>BARNEY</b> c. (Last) <b>DELLBRINGE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>4-8-1957</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED/WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>5-17-1878</b>		9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					

13a. FATHER'S NAME <b>Henry B. Dellbringe</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Hazel</b>		14. NAME OF HUSBAND OR WIFE <b>Emilie Dellbringe</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Spanish American War</b>		16. SOCIAL SECURITY NO. <b>457-20-0832</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Emilie Dellbringe</b>	
				ADDRESS <b>2703 Missouri Ave</b>	

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)		<b>Chr. nephritis</b>				
ANTECEDENT CAUSES		DUE TO (b) <b>arteriosclerosis</b>				
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <b>cataracts</b>				
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 <b>446x</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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 Jan 1, 1957 to 4-8, 1957, that I last saw the deceased alive on 4-1, 1957, and that death occurred at 5:55 A.M., from the causes and on the date stated above.

23a. SIGNATURE <b>H.S. Pyne M.D.</b>		23b. ADDRESS <b>2752 Cherokee</b>		23c. DATE SIGNED <b>4-8-57</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>4-10-1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery</b>	
				24d. LOCATION (City, town, or county) (State) <b>7901 Gravois Ave Mo</b>	

DATE REC'D BY LOCAL REG. <b>APR 9 57</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		FUNERAL DIRECTOR'S SIGNATURE <b>MS Siegenbauer</b>	
				ADDRESS <b>6409 Gravois Ave</b>	

Dr. Pyne 2752 Cherokee St  
PR 2-0244  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED STATE DEPT. OF HEALTH  
MAY 10 1934

1934-5-10	1934-5-10	1934-5-10	1934-5-10	1934-5-10	1934-5-10
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1934-5-10	1934-5-10	1934-5-10	1934-5-10	1934-5-10	1934-5-10

STATEMENT BY LICENSED EMBALMER

*John M. Simon*

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 *John M. Simon*

Licensed Embalmer No. *4343*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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