

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007041
STATE FILE NUMBER
1419

FILED FEB 28 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 1419

300
1-57

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. # 1		Length of stay in lb		d. STREET ADDRESS (If outside, give location) 2678 2701 N. 9TH	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Last BRANDL			4. DATE OF DEATH Month FEB. 5, 1958 Day Year		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 27, 1891	9. AGE (In years (birthday)) 66	F UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life; if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY?
UNEMPLOYED			MISSOURI		U.S.A.
13a. FATHER'S NAME LOUIS BRANDL		13b. MOTHER'S MAIDEN NAME KATHERINE KRAUSE		14. NAME OF HUSBAND OR WIFE	
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 Address ELIZABETH BRANDL 1911 President		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Staphylococcal Pneumonia DUE TO (b) Staphylococcus DUE TO (c) Malnutrition & dehydration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 490x		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1/29/58 to 2/5/58 and last saw her alive on 2/5/58 Death occurred at 3:05 AM m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE H. E. Best M.D.			22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 2/5/58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Feb 7, 1958	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION Cem.		23d. LOCATION (City, town, or county) (State) ST. LOUIS Co. Mo
24. FUNERAL DIRECTOR Thomas Kutis 2906 Spruvs		25. DATE RECD. BY LOCAL REG. FEB 7 '58	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. M. J. R.		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Samuel C. Hill*

Licensed Embalmer No. *4347*

P. O. Address *2906 Shaw*

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.