

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007052
STATE FILE NUMBER

FILED FEB 28 1958

318

1003

1996

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Mo. St. Louis Mo.</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis 12, Missouri</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Masonic Home Of Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>7</u> c. CITY OR TOWN <u>St. Louis</u> d. STREET ADDRESS (If outside, give location) <u>5351 Delmar Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Millie</u> Middle <u></u> Last <u>Bruns</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>91</u>
13. FATHER'S NAME <u>Alexander Lightstone</u>		11. BIRTHPLACE (City and state or country) <u>New York City, N. Y.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
16. SOCIAL SECURITY NO. <u>None</u>		14. MOTHER'S MAIDEN NAME <u>Dena Horstmeyer</u>	
17. INFORMANT <u>Masonic Home of Missouri-5351 Delmar Blvd.</u>		17. INFORMANT Address <u>5351 Delmar Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, with left hemiplegia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerosis, Generalized</u> <u>4200</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>2 years</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.)		
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>			
20d. INJURY OCCURRED WHILE AT WORK <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 <u>2/4/56</u> to <u>2/18/58</u> and last saw her/him alive on <u>2/18/58</u> Death occurred at <u>12:45</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert A. Hall, M. D.</u>		22b. ADDRESS <u>3902a Lafayette</u>	22c. DATE SIGNED <u>2/19/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>2-20-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
24. FUNERAL DIRECTOR <u>Calvin F. Feutz</u> ADDRESS <u>4828 Natural Bridge</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 19 '58</u>	
26. REGISTRAR'S SIGNATURE <u>J. Carl Smith Mo</u> <u>m 83</u>			

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare public service
300 1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *John A. Mlenar*

Licensed Embalmer No. *41*

P. O. Address *Sp. Loc.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.