

with, welfare, public, twice

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009412
STATE FILE NUMBER

FILED APR 7 1958

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 109

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rosebud</u> <u>0370</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>		Length of stay in 1b <u>7 hrs.</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Brinkmann</u> Last <u>Brinkmann</u>			4. DATE OF DEATH Month <u>April</u> Day <u>2</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"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1886</u>	9. AGE (In years past birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Hope, Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Samuel Sutter</u>		13b. MOTHER'S MAIDEN NAME <u>Louise Boeger</u>		14. NAME OF HUSBAND OR WIFE <u>Henry F. Brinkmann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Cecil Roy Adams Rosebud, Mo.</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 concussion and multiple skull fractures plus fracture of rib cage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>whs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>multiple skull fractures</u> DUE TO (c) <u>plus fracture of rib cage</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>9020</u> <u>21</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>slipped fall from porch at home</u>				
20c. TIME OF INJURY <u>4:00 p.m.</u>	Hour <u>4</u> Month <u>11</u> Day <u>15</u> Year <u>1958</u>	20d. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <u>home</u>			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Rosebud</u>		COUNTY <u>Gasconade</u>	STATE <u>MO</u>	
21. I attended the deceased from _____, to _____, and last saw her/him alive on _____ Death occurred at <u>1:40 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>E. J. Stumpe Sr.</u> (Degree or title)			22b. ADDRESS <u>1000 Union St</u>		22c. DATE SIGNED <u>4/4/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>4-5-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. James E & R Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>near Drake, Mo.</u>	
24. FUNERAL DIRECTOR <u>Gottenstroeter Funeral Home</u>		ADDRESS <u>Owensville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4/4/58</u>	26. REGISTRAR'S SIGNATURE <u>J.P. Stumpe</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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Wm. H. Winter, Owensville, Mo. (Registered Embalmer's Statement on Reverse Side)

MAY 15 1958

JUN 17 1959

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 *Ernest L. Ottmann*

Licensed Embalmer No. *4054*
P. O. Address *Genoa, Ill.*

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.