Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020452
STATE FILE NUMBER

FILED MAY 26 1958 Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1366

1. PLACE OF DEATH
a. COUNTY St.Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Webster Groves — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 461 Florence — Length of stay in 1b YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St.Louis
c. CITY OR TOWN Webster Groves 4617 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 461 Florence — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First John Middle Last Bruck
4. DATE OF DEATH Month May Day 20, Year 1958
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH Nov. 25, 1868
9. AGE (In years last birthday) 89 — 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) retired
10b. KIND OF BUSINESS OR INDUSTRY auto. worker
11. BIRTHPLACE (City and state or country) St.Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Bruck
14. MOTHER'S MAIDEN NAME Sophia Dierkes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ------
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Mrs.Charlotte E.Bretz-Webster Groves

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis
DUE TO (c) 331X
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 ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1-5-53, to May 20, 1958 and last saw her/him alive on May 2, 1958
Death occurred at 11:00 Am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. J. Vollmar [illegible]
22b. ADDRESS 55 W. Big Bend
22c. DATE SIGNED 5/21/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE May 22,1958
23c. NAME OF CEMETERY OR CREMATORY St.Paul's Churchyard
23d. LOCATION (City, town, or county) (State) St.Louis County, Missouri
24. FUNERAL DIRECTOR ADDRESS WACKER-HELDERLE-3634 Gravois Ave.
25. DATE RECD. BY LOCAL REG. 5-21-58
26. REGISTRAR'S SIGNATURE Herbert R. Donke M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.