

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010753
STATE FILE NUMBER
2 3062

FILED APR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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-57

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|---|----------------------------------|---|---|--|---|
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1. | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) 447 N. Sarah St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle Last BRUENING | | | 4. DATE OF DEATH Month MARCH Day 24 Year 1959 | | |
| 5. SEX Male ^C | 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 Nov. 1, 1885 | | 9. AGE (In years for birthday) 73 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 Steel Worker | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13a. FATHER'S NAME Gerhardt Bruening | | 13b. MOTHER'S MAIDEN NAME Mary Schellert | | 14. NAME OF HUSBAND OR WIFE Pearl | |
| 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. 489-05-0277 | | 17. INFORMANT Address Adele DeWitt, 2408 Caverhill Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) Thrombosis of coronary artery DUE TO (c) Coronary arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1 | | | | | INTERVAL BETWEEN ONSET AND DEATH week |
| 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.) 420.1 | | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____ | | | | | |
| 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 3/18/59 , to 3/24/59 and last saw her alive on 3/24/59 Death occurred at 10:05 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE John D. Chapman M.D. (Degree or title) | | 22b. ADDRESS 3515 LAFAYETTE AVE | | 22c. DATE SIGNED 3/24/59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3-27-59 | | 23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery | |
| | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd. | | | 25. DATE RECD. BY LOCAL REG. MAR 26 '59 | | 26. REGISTRAR'S SIGNATURE Robert Smith, M.D. |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

-m, B.

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 *Greg W. Wehner*

Licensed Embalmer No. *3575*

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