

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011581
STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 848

1. PLACE OF DEATH a. COUNTY ST. LOUIS, COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON, MO.		c. CITY OR TOWN CLAYTON, MO. 4467	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSP. 517AS.		d. STREET ADDRESS (If outside, give location) #99 ABERDEEN, PL.	

3. NAME OF DECEASED (Type or print) First Middle Last Joseph WEIS Bresler.			4. DATE OF DEATH Month Day Year March 29, 1959		
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 AUG. 13TH 1869	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY HIS, OWN. TUSCUMBIA, ALABAMA.		11. BIRTHPLACE (City and state or country) U.S.A.	

13a. FATHER'S NAME ABRAHAM BRESLER		13b. MOTHER'S MAIDEN NAME BERTHA WEIS		14. NAME OF HUSBAND OR WIFE ROSA, D. BRESLER, DECD.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO NONE		16. SOCIAL SECURITY NO. 489-28-7371		17. INFORMANT MILTON, W. BRESLER - U. G. CITY (S) DRIVE	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Cardiac Decompensation			
DUE TO (c) Arteriosclerotic Heart Disease 4200			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Generalized Arteriosclerosis - marked; Benign Prostatic Hypertrophy

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.)
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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
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21. I attended the deceased from 3-24-59 to 3-29-59 and last saw him alive on 3-29-59 Death occurred at 8:10 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. H. Garrison, Jr. M.D.	22b. ADDRESS 6015 S. Brentwood, Clayton, Mo.	22c. DATE SIGNED 3-29-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE MARCH 31ST 1959	23c. NAME OF CEMETERY OR CREMATORY VAL HALLA - CREMATORY, ST. LOUIS, COUNTY, MO.	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR ADDRESS Brockland and Co. 1827 HOGAN ST.	25. DATE RECD. BY LOCAL REG. 3-29-59	26. REGISTRAR'S SIGNATURE John C. Murphy M. D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MS SEP 1 1958

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 J. Harris*
Licensed Embalmer No. *4108*
P. O. Address *St. Louis*

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.