

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022736

STATE FILE NUMBER

Registrar's **2 5686**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN 4010 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		Length of stay in 1b	d. STREET (If outside, give location) ADDRESS 9734 Diamond Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First JOHN	Middle JOSEPH	Last BRUZAITIS	4. DATE OF DEATH	Month June	Day 12	Year 1959
-------------------------------------	-------------------	----------------------	-----------------------	------------------	-------------------	---------------	------------------

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1917	9. AGE (In years of birthday) 41	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) Millwright-General Cable Corp.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	-----------------------------------	--	---

13a. FATHER'S NAME Anthony J. Bruzaitis	13b. MOTHER'S MAIDEN NAME Ursula Adukite	14. NAME OF HUSBAND OR WIFE Geraldine Bruzaitis
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. II	16. SOCIAL SECURITY NO.	17. INFORMANT Geraldine Bruzaitis - St. Louis, Mo.	Address
--	-------------------------	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intercranial Aneurysm & Rupture		INTERVAL BETWEEN ONSET AND DEATH 1 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 330x		
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 checked="" type="checkbox"/> NO <input 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 _____ 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 _____ 4-27-59 _____ 6-12-59 and last saw ^{her} him alive on 6/12/59 Death occurred at _____ 6/12/59 _____ on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) G. A. Smoel, M.D.	22b. ADDRESS 100 N. Euclid St. Louis, Mo.	22c. DATE SIGNED 6/15/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/16/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
--	-----------------------------	---	---

24. FUNERAL DIRECTOR John J. Kasey III	ADDRESS E. St. Louis, Ill.	25. DATE RECD. BY LOCAL REG. JUN 15 59	26. REGISTRAR'S SIGNATURE Roald Smith, M.D.
--	--------------------------------------	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Not Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed A. M. Decker

Licensed Embalmer No.....

P. O. Address.....

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.