

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033611

FILED VS. SEP 21 1959

2 8271

STATE FILE NUMBER

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 7 weeks		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 DePaul Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4245 Neosho		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Erna E. Brodbeck				4. DATE OF DEATH Month Day Year 9/6/59				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1899	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary			10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (City and state or country) Waukegan, Ill.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Louis J. Brodbeck			13b. MOTHER'S MAIDEN NAME Alma F. Hauschild			14. NAME OF HUSBAND OR WIFE ----		
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. ---		17. INFORMANT Address Mrs. Ione Binder-3911 Winnebago			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Suprarenal gland & Metastasis to pleural cavities - Origin Unknown.							INTERVAL BETWEEN ONSET AND DEATH 6 mos?	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) gland & Metastasis to pleural cavities - Origin Unknown.								
DUE TO (c) gland & Metastasis to pleural cavities - Origin Unknown.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) none						
20c. TIME OF INJURY (Hour a.m. p.m.) none		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from July 16 59 to Sept 6 59 and last saw her him alive on Sept 5 59 Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Name or title) M. Staeckle M.D.				22b. ADDRESS 7124 Natural Bridge			22c. DATE SIGNED Sept 8 59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 9/9/59	23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
24. FUNERAL DIRECTOR ADDRESS WACKER-HELDERLE 3634 Gravois				25. DATE RECD. BY LOCAL REG. SEP 8 '59		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Embalmed
no

Signed *Robert J. Krupnik*

Licensed Embalmer No. *3491*

P. O. Address *St. Francis*

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.