

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038265

FILED VS NOV 16 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2885

RECEIVED

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		Length of stay in 1b YRS.		c. CITY OR TOWN Clayton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6300 Alamo Avenue			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6300 Alamo Avenue			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Herman Middle W. Last Bromeyer				4. DATE OF DEATH Month 10 Day 29 Year 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 10/5/67	9. AGE (last birthday) 92	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer (ret.)			10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (City and state or country) Centralia, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Henry Bromeyer			13b. MOTHER'S MAIDEN NAME -			14. NAME OF HUSBAND OR WIFE Rosa L. Bromeyer	
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 Miss Clara Bromeyer, 6300 Alamo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 10 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertrophy of prostate							5 years.
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year					
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 _____ to _____ and last saw her/him alive on _____. Death occurred at 9:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Monty John Everell M.D.				22b. ADDRESS 6356 Clayton Rd. St. Louis Mo.		22c. DATE SIGNED 10-30-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 10/31/59	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum		23d. LOCATION (City, town, or county) St. Louis County		(State) Mo.
24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral 1905 Union Blvd.			25. DATE RECD. BY LOCAL REG. 10-30-59		26. REGISTRAR'S SIGNATURE John B. Murphy M.D.		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. N. J. Eversohl
6356 Clayton Road
St 1-4060
Hrs. 11-5 P.M.

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 Albert R. Thompson

Licensed Embalmer No. 4237

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.