

FEDERAL BUREAU OF INVESTIGATION  
**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-003183**

**FILED VS JAN 22 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **B 196** STATE FILE NUMBER

UNDE

|   |                                  |   |   |   |  |   |   |
|---|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY |  |   |   |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis, Missouri</b>   |                                  |   | Length of stay in 1b  |   | c. CITY OR TOWN <b>ST. Louis</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Louis City Hosp # 1</b>   |                                  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>2416 WINNEBAGO</b>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle Last <b>Brinda</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>4th</b> Year <b>1960</b>  |  |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>5-21-1888</b>  | 9. AGE (last birthday)<br><b>71</b>  | IF UNDER 1 YEAR<br>Months Days                | IF UNDER 24 HR<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SHOE WORKER</b>                   |   | 11. BIRTHPLACE (City and state or country)<br><b>Mo.</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>  |
| 13a. FATHER'S NAME<br><b>JOSEPH BRINDA</b>  |                                  |   | 13b. MOTHER'S MAIDEN NAME<br><b>MARY MARCS</b>                            |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>-</b>       |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)<br><b>Yes</b>  |                                  |   | 16. SOCIAL SECURITY NO.<br><b>488-07-0458</b>                             |   | 17. INFORMANT<br><b>MARY PUTTHOFF</b> Address <b>3416 WINNEBAGO</b>  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO (b) <b>CAS</b><br>DUE TO (c)<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>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 <b>1-3-60 4:35A.M.</b> to <b>1-4-60</b> and last saw her/him alive on <b>1-4-60</b><br>Death occurred at <b>7:45P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.                                  |                                  |   |   |   |  |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>Robert B. Stern, M.D.</b>  |                                  |   |   | 22b. ADDRESS<br><b>1515 Lafayette Avenue</b>  |  | 22c. DATE SIGNED<br><b>1-4-60</b>             |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county) (State) |   |
| <b>BURIAL</b>   |                                  | <b>JAN 8, 1960</b>  |   | <b>S. S. POTERF PAUL CEM</b>  |  | <b>ST. LOUIS Mo</b>                           |   |
| 24. FUNERAL DIRECTOR<br><b>Thomas Kuti</b> ADDRESS <b>2906 Garrison</b>   |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><b>JAN 7 1960</b>                         |   | 26. REGISTRAR'S SIGNATURE<br><b>Robert B. Stern, M.D.</b>  |   |   |

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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James C. Hill

Licensed Embalmer No. 4347  
P. O. Address 2606 S

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.