

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS/ OCT 1 0 1960

60-037003

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2835 STATE FILE NUMBER

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| 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 Valley Park, | | Length of stay in lb 2 days | c. CITY OR TOWN Affton, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Moll Nursing Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 10923 Tesson Ferry Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First CHARLES Middle E. Last BRINE | | | 4. DATE OF DEATH Month Sept. Day 24th, Year 1960 | | |
| 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 8-21-1886 | 9. AGE (last birthday) 74 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman-Retd. | | 10b. KIND OF BUSINESS OR INDUSTRY Sodeman Heat & Power | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME ALFRED BRINE | | 13b. MOTHER'S MAIDEN NAME LOUISE BRYANT | |
| 14. NAME OF HUSBAND OR WIFE Lena Brine | | 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. 492-05-7392 | |
| 17. INFORMANT Lena Brine-10923 Tesson Ferry Rd. | | 17. INFORMANT Address | | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 9-18-60 |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio-Sclerosis | | |
| 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 |

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| 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 a.m. p.m. | Month, Day, Year | |

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|---|--|------------------------------|--------|-------|
| 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 <u>3-29-57</u> to <u>9-21-60</u> and last saw him alive on <u>9-21-60</u> Death occurred at <u>9:18 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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| 22a. SIGNATURE (Degree or title) <i>Carl E. Buck M.D.</i> | | 22b. ADDRESS <i>Wheaton Groves</i> | 22c. DATE SIGNED <i>9-26-60</i> |
| 22d. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Sept. 27, 1960 | 23c. NAME OF CEMETERY OR CREMATORY Mt Hope Cem. | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. |
| 24. FUNERAL DIRECTOR ADDRESS Kriegshauser-4228 S. Kingshighway Blvd. | | 25. DATE RECD. BY LOCAL REG. 9-26-60 | 26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i> |

DOCUMENT

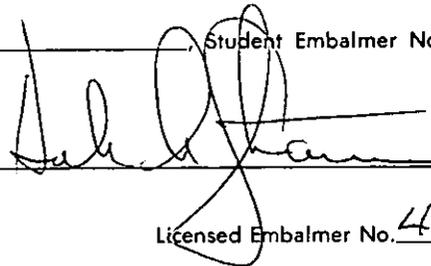
MEDICAL CERTIFICATION

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  _____
Licensed Embalmer No. 4533

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.