

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4000

1. PLACE OF DEATH a. COUNTY 2 yrs.		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 1b 4 mo. 6 days	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3417a Roger Pl.
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last **Catherine M. Braun**

4. DATE OF DEATH Month Day Year **4-25-61**

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 12-17-1879	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress (Retired) Self	10b. KIND OF BUSINESS OR INDUSTRY Employed	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME **John Braun** 13b. MOTHER'S MAIDEN NAME **Josephine Severin** 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 None

16. SOCIAL SECURITY NO. **None** 17. INFORMANT Address **Rose L. Thieser 5027a Sutherland Ave.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Bronchopneumonia**
 DUE TO (b) _____
 DUE TO (c) _____

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. **491X**

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 **12-18-58** to **4-25-61** and last saw her alive on **4-25-61**
 Death occurred at **9:15 a.m.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **[Signature]** (Degree or title) 22b. ADDRESS **5600 Arsenal St.** 22c. DATE SIGNED **4-26-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **Apr. 27, 1961** 23c. NAME OF CEMETERY OR CREMATORY **Resurrection Cemetery** 23d. LOCATION (City, town, or county) (State) **St. Louis Co., Mo.**

24. FUNERAL DIRECTOR ADDRESS **Kriegshausen 4228 S. Kingshighway Blvd.** 25. DATE RECD. BY LOCAL REG. **APR 26 1961** 26. REGISTRAR'S SIGNATURE **[Signature]**

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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

Signed

Ernest W. Spillar

Licensed Embalmer No. 4080

P. O. Address 4228 So King

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.