

AMENDED

Registration District No. **FILED OCT 13 1961**

Primary Registration District No. **1003**

Registrar's No. **9101**

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				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 St. Louis		Length of stay in 1b		c. CITY OR TOWN Lemay		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 613 Kayser St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First August Middle W. Last Breihan				4. DATE OF DEATH Month October Day 2 Year 1961											
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 11-4-1882		9. AGE (last birthday) 78		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker-Retired				10b. KIND OF BUSINESS OR INDUSTRY National Lead Co.		11. BIRTHPLACE (City and state or country) St. Louis Co., Mo.		12. CITIZEN OF WHAT COUNTRY U S A							
13a. FATHER'S NAME August Breihan				13b. MOTHER'S MAIDEN NAME Sophie Lindhorst				14. NAME OF HUSBAND OR WIFE Dina							
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 Albert Breihan 613 Kayser St. Lemay, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infection; DUE TO (b) Atherosclerosis. DUE TO (c) 450.0 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? 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 Hour a.m. 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 _____ on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <i>Joseph M. Hoffman</i>						22b. ADDRESS 1300 Clark				22c. DATE SIGNED 10-3-61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-5-1961		23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery				23d. LOCATION (City, town, or county) (State) 2000 Lemay Ferry Rd. Lemay, Mo.							
24. FUNERAL DIRECTOR C. Hoffmeister Mortuaries 7814 S. Broadway				25. DATE RECD. BY LOCAL REG. OCT 3 1961				26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>							

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 John S. Pennehy

Licensed Embalmer No. 4194

P. O. Address St. Louis, Mo.

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.