

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-035956

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8840** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 17 1962

| | | |
|--------------|---|--------------|
| VS 300 | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF | DATE AMENDED |
| Rev. 4/59 | | |
| 1 | | |
| 2 20 | | |
| 3 | | |
| 4 1 | | |
| 5 2 | | |
| 6 | | |
| 7 2 | | |
| 8 2 | | |
| 9 | | |
| 10 | | |
| 11 | | |
| 12 86 | | |
| 13 | | |
| | ITEM NO. | SHOULD READ |
| | BY AFFIDAVIT OF | DOCUMENT |

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 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 | | c. CITY OR TOWN St. Louis | |
| Length of stay in lb | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Medical Center | | d. STREET ADDRESS (If outside, give location) 5750 Pershing Ave | |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ricka Struck Brahms | | | 4. DATE OF DEATH Month Day Year September 12, 1962 |
| 5. SEX Female | 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 9/2/1875 |
| 9. AGE (last birthday) 87 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (City and state or country) Dorfranzau, Germany |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME Wilhelm Struck | |
| 13b. MOTHER'S MAIDEN NAME Dora Buening | | 14. NAME OF HUSBAND OR WIFE Chris B. Brahms | |
| 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. None | 17. INFORMANT Address Miss Alice Brahms 5750 Pershing 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) Myocardial Failure | | | INTERVAL BETWEEN ONSET AND DEATH 1 mo. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease | | | Years |
| DUE TO (c) 420.0 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Left hemiplegia from stroke 1 mo. ago | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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 4-16-1957 to 9-11-62 and last saw her/him alive on 9-6-62 Death occurred at 5:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) V. O. Fish M.D. | | 22b. ADDRESS 634 N. Grand Ave. St. Louis, Mo | 22c. DATE SIGNED 9-12-62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail) | 23b. DATE 9/13/62 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | 23d. LOCATION (City, town, or county) (State) Davenport, Iowa |
| 24. FUNERAL DIRECTOR ADDRESS Alexander & Sons 6175 Delmar Blvd | | 25. DATE RECD. BY LOCAL REG. SEP 12 1962 | 26. REGISTRAR'S SIGNATURE Loat Smith, M.D. |

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Virgil O. Fish

Mo. Theatre Bldg

Fr. 1-5588

1 to 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 jos E Mc Cullok

Licensed Embalmer No. 2450

P. O. Address 6175 Duncanson

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.