

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-018458

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1259

STATE FILE NUMBER

**FILED MAY 8 1963**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5360 Ruskin Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>OLIVER</u> Middle <u>G.</u> Last <u>BRUENING</u>			<b>4. DATE OF DEATH</b> Month <u>Apr.</u> Day <u>12,</u> Year <u>1963</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <u>Never Married</u> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2-21-07</u>	<b>9. AGE (last birthday)</b> <u>56</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Board of Educ.</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Louis, Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>Henry Bruening</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Rose Bruening</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>Elizabeth Bruening</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u> <u>None</u>			<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <u>Mrs. Elizabeth Bruening 5360 Ruskin</u>		

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Dis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>1 1/2 yrs</u> <u>1 1/2 yrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus, Gout, Lobar Pneumonia</u>		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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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED:</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____					

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> _____	COUNTY _____	STATE _____
<b>21. I attended the deceased from</b> <u>1/28/61</u> to <u>4/12/63</u> and last saw <sup>him</sup> <u>him</u> alive on <u>4/12/63</u> Death occurred at <u>9:50 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

<b>22a. SIGNATURE</b> (Degree or title) <u>Murray Chinsky, M.D.</u>		<b>22b. ADDRESS</b> <u>6223 Nat. Bridge</u>		<b>22c. DATE SIGNED</b> <u>4/15/63</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>23b. DATE</b> <u>16 Apr 63</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Calvary Cemetery</u>	
				<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis, Missouri.</u>	

<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>JOHN STYGAR &amp; SON - 5541 RIVERVIEW BLVD.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>4-15-63</u>		<b>25. REGISTRAR'S SIGNATURE</b> <u>John Muffley M.D.</u>		
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AMENDED  
 VS 300 Rev. 4/59  
 1 4005  
 2 307  
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 4 0  
 5 1  
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 7 0  
 8 2  
 9 94200  
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 12 46-0  
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 46  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF  
 USE BLACK INK OR TYPEWRITER RIBBON

**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 *J. M. Rister*

Licensed Embalmer No. 3980

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.