

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-022500

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 1587

FILED MAY 27 1963

VS'300 Rev. 4/59	DATE AMENDED		DOCUMENT
1 <u>4000</u>			
2 <u>8020</u>			
3 <u>2</u>			
4 <u>0</u>			
5 <u>1</u>			
6			
7 <u>1</u>			
8 <u>1</u>			
9 <u>342X</u>			
10			
11			
12 <u>48-0</u>			
13			
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS		INSTEAD OF	BY AFFIDAVIT OF
USE BLACK INK OR TYPEWRITER RIBBON	SHOULD READ		

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARIZONA b. COUNTY MARICOPA	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MISSOURI		Length of stay in 1b 25 DAYS	c. CITY OR TOWN PHOENIX Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADMIN. HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1609 E. WILLETTA Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD H. BREITHAUPT			4. DATE OF DEATH Month Day Year MAY 14th, 1963
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 7-7-14
9. AGE (last birthday) 48 YEARS		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (City and state or country) JENA, LOUISIANA
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME WILLIAM BREITHAUPT	
13b. MOTHER'S MAIDEN NAME MRS PARSON		14. NAME OF HUSBAND OR WIFE MAE C. BREITHAUPT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWII & KOREAN		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT (Name and Address) (Wife) 1609 E. Willetta MAE C. BREITHAUPT Phoenix, Arizona
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ABSCESS, RIGHT PARIETAL AREA			INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS APPROX.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last: DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Focal obstructive pneumonitis and Bronchiectasis due to bronchololith (right upper lung lobe)			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. Attended attended the deceased from 4-19-63 to 5-14-63		XXXXXXXXXXXX	
Death occurred at 6:50 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul G. Stromsdorfer (Degree or title) <i>Paul G. Stromsdorfer</i>		22b. ADDRESS VET. ADM. HOSP. : JEFF. BRKS., MO. (25)	22c. DATE SIGNED 5-14-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-15-63	23c. NAME OF CEMETERY OR CREMATORY Froest Park Cemetery	23d. LOCATION (City, town, or county) (State) Shreve Port La.
24. FUNERAL DIRECTOR White-Mullen 118 N. Florissant Rd. Ferg.		25. DATE RECD. BY LOCAL REG. 5-15-63	26. REGISTRAR'S SIGNATURE <i>John B. Murphy 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 Reinhold K. Lohmann

Licensed Embalmer No. 3395

P. O. Address # Louis 35 MD

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.