. S. No. 2
0M—5-43
v. 5-17-39
I X36871

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3299

FILED FEB 13 1945

Registration District No. 17 Primary Registration District No. 3069 Registrar's No. 398

1. PLACE OF DEATH:

(a) County St Louis Co.

(b) City or town RICHMONDS HEIGHTS MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Marys Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
In this community 28 Yrs 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Mo (b) County 17

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 9

(d) Street No. 5340 Nottingham (If rural, give location)

(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Conrad W Brehe

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Amanda

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Oct (Month) 24 (Day) 1899 (Year)

8. AGE: Years 45 | Months 3 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Kansas (City, town, or county) / (State or foreign country)

10. Usual occupation Salesman

11. Industry or business St. Louis Dairy

MOTHER FATHER

12. Name Eichard Brehe

13. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

MOTHER FATHER

14. Maiden name Louise Lewecke

15. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

16. (a) Informant Amanda Brehe

(b) Address 5340 Nottingham Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (Month) 6 (Day) 45 (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director KRIEGSHAUSER

(b) Address 4228 So. Kingshighway

19. (a) FEB 9 1945 (Date received by local registrar) (b) E. L. Mathews (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb day 2
year 1945 hour 9 AM minute ____ M.

21. I hereby certify that I attended the deceased from Oct. 22, 1944, to Feb. 2, 1945
that I last saw him alive on Feb 1, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac failure	2 days
Due to: acute Pemphigus	3½ Mo
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 153.1	
Of autopsy:	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (c) Means of injury

23. Signature T. J. Mathews (M.D. or other)

Address 634 No Grand Date signed 2/5/45

(Licensed Embalmer's Statement on Reverse Side)

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 .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Richard W. Storsand

Licensed Embalmer No. 4007

P. O. Address .....

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 this body is not embalmed, fact should be so stated above.