

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

23382

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City..... (No. **1354**) St. _____ Ward _____

File No.
 Registered No. **6868**

2. FULL NAME *Henry Brewer*

(a) Residence. No. _____ St. **21** Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *5-7-29*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>0</i>	<i>1</i>	<i>20</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. _____
 (b) General nature of industry, business, or establishment in which employed (or employer). _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *St Louis, Missouri*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Henry Brewer*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Tenn*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Beatrice Hardin*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Miss*
 (STATE OR COUNTRY)

14. INFORMANT *Henry Brewer*
 (Address) *1354 S. Ferguson*

15. FILED *JUN 29 1929* *Mat C. Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-27-29*

17. I HEREBY CERTIFY, That I attended deceased from _____, 1929, to *6-27-29*, 1929, that I last saw *him* alive on *6-27-29*, and that death occurred, on the date stated above, at *6 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Valvulus (intestinal obstruction)
11801 (duration) _____ yrs. _____ mos. *7* ds.

CONTRIBUTORY (SECONDARY) *Valvulus (intestinal obstruction)*
 (duration) _____ yrs. _____ mos. *7* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. *unknown*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *symptoms*

(Signed) *L. C. Bennett* M. D.

, 19 (Address) *239th St. Jefferson*

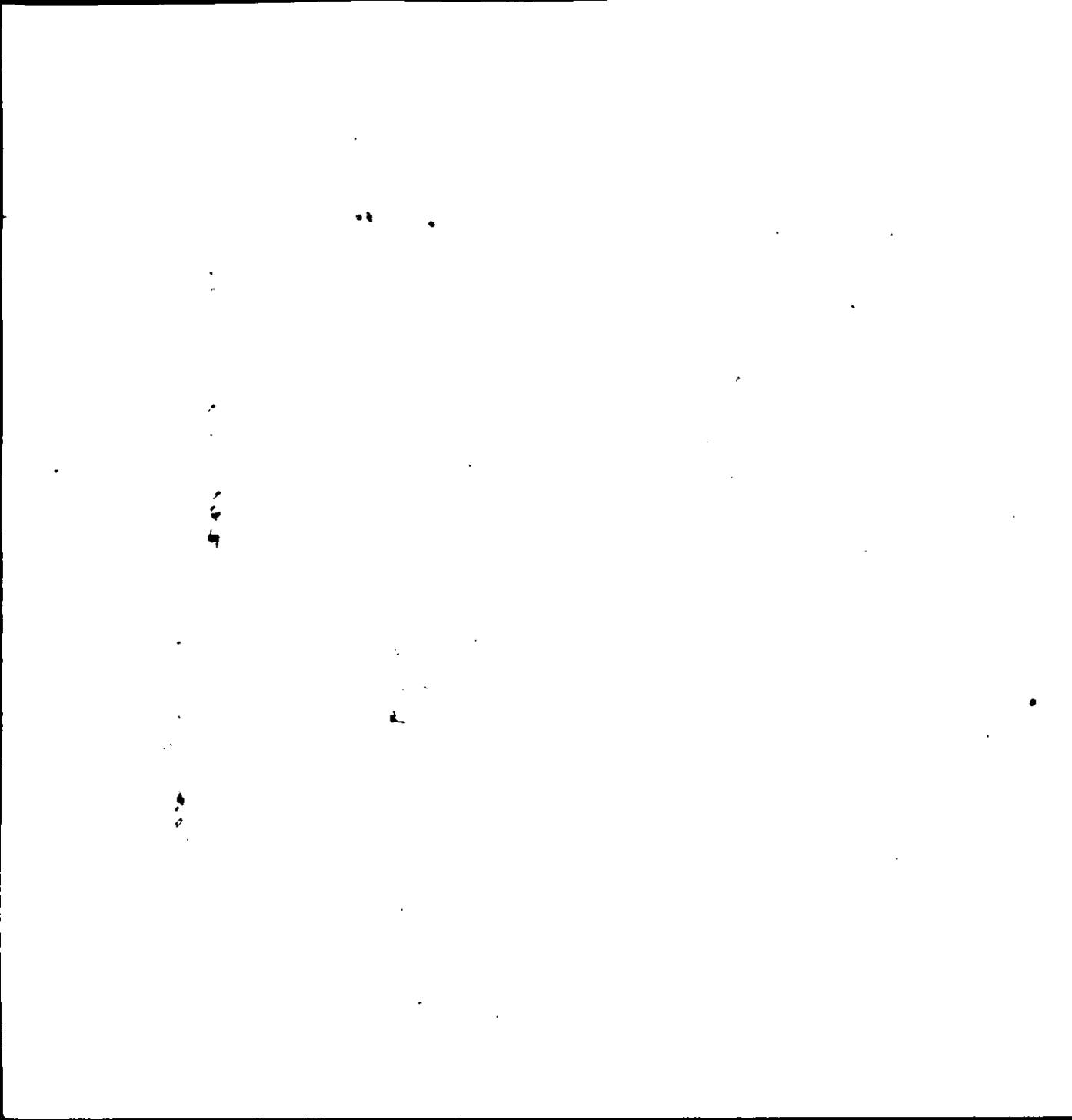
*State the DISEASE CAUSING DEATH, or in deaths from violent causes, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Greenwood Cem *6-27-29*

20. UNDERTAKER ADDRESS

Walden and Son *2741 Chestnut*



**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. **6868**
City..... (No. **1354**, **Glasgow**) St. Ward)

2. FULL NAME *Henry Bussan*
(a) Residence. No..... St., Ward,
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* | **4. COLOR OR RACE** *B* | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 7/1929*

7. AGE YEARS MONTHS DAYS *1 20*
If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employee).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY)

10. NAME OF FATHER *Henry Bussan*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Tenn.*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Edith Hardy*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Miss*
(STATE OR COUNTRY)

14. INFORMANT (Address)

15. *Max G. Starkeoff*
FILED *11 1930* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 27 19 29*

17. I HEREBY CERTIFY, That I attended deceased from to
that I last saw h..... since on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration)..... yrs. mos. ds.
CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPT?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | **DATE OF BURIAL**

20. UNDERTAKER | ADDRESS

19

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-23382