

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

Do not use this space.

14418

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis (No. 19 St. Channing)

File No.....  
Registered No. 3762  
St. .... Ward)

**2. FULL NAME**

Arthur Brewster  
(a) Residence. No. 19 St. Channing St. 18 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 <u>Male</u>	4. COLOR OR RACE <u>Coe</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 21 1892</u>		
7. AGE	YEARS	MONTHS
	<u>37</u>	<u>10</u>
		DAYS
		<u>23</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work. <u>Cobblers</u>		
(b) General nature of industry, business, or establishment in which employed (or employer). <u>odd jobs</u>		
(c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN)..... Texas  
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Morris Brewster</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... <u>Texas</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Georgia Ann</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... <u>Texas</u> (STATE OR COUNTRY)

14. INFORMANT Walter B. Brewster  
(Address) 2930 Pine St.

15. FILED APR 15 1930 W. C. Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 14, 1930  
17. No Physician in attendance  
I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 3:40 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Myocarditis  
(duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) NO  
(duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED.....  
IF NOT AT PLACE OF DEATH.....  
8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY? Yes  
WHAT TEST CONFIRMED DIAGNOSIS.....  
(Signed) W. C. Stanley, M.D.  
4/15 1930 (Address) Deputy Coroner

\*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 <u>FATHER DICKSON</u>	DATE OF BURIAL <u>4/16 1930</u>
20. UNDERTAKER <u>Gates</u>	ADDRESS <u>4107 Quincy Ave.</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

