

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

Do not use this space.

17612

1. PLACE OF DEATH

County Registration District No.
Township Primary Registration District No.
City *St. Louis* (No. *City Hospital*)

791
1003

File No.
Registered No. **4540**
St. Ward)

2. FULL NAME

(a) Residence, No. *1815 So 9th St.*, *23* Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *45* 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 *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 10 - 1866*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>66</i>		<i>28</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Barber*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *self 226*

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) *Scalor* (STATE OR COUNTRY) *Missouri*

13. NAME *Amos Brewson*

14. BIRTHPLACE (CITY OR TOWN) *Ohio* (STATE OR COUNTRY)

15. MAIDEN NAME *Mary Smith*

16. BIRTHPLACE (CITY OR TOWN) *Iowa* (STATE OR COUNTRY)

17. HOSPITAL INFORMATION (ADDRESS) *City Hospital*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Geord* DATE *5-10-1932*

19. UNDERTAKER (ADDRESS) *Peets Bros 3028 Lafayette*

20. FILED *MAY - 9 1932* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 8th 1932*

22. I HEREBY CERTIFY, That I attended deceased from *May 7th 1932 to May 8th 1932*
I last saw him alive on *May 8th 1932* Death is said to have occurred on the date stated above at *9:00 a.m.*

The principal cause of death and related causes of importance were as follows:

Acute staphylococci meningitis
131
890
79A
Other contributory causes of importance:
Chy mastoiditis, left.
Chy nephritis

Name of operation Date of
What test confirmed diagnosis? *micro* Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) *M. M. Macintosh*, M. D.
City Hospital (Address)

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.

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