

REC'D MAY 20 1938

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

Do not use this space.

14765

1. PLACE OF DEATH

County

Henry

Registration District No.

364

File No.

Township

Stark

Primary Registration District No.

5509

Registered No.

4

City

Preston Mo. (No. _____)

St.

Ward)

2. FULL NAME

Elizabeth Brewster

623 40...

(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 W	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W R Brewster		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 5, 1848		
7. AGE	YEARS	MONTHS
	89	7
		DAYS
		5
	If LESS than 1 day,hrs. ormin.	

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation.
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
	13. NAME

MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
	15. MAIDEN NAME

MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
	17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL	DATE
PLACE	4 14 1938

19. UNDERTAKER (ADDRESS)
20. FILED

20. FILED	April 4, 1938	J M Robertson	Registrar.
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MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 10, 1938

22. I HEREBY CERTIFY, That I attended deceased from Jan 15 to Jan 15, 1937

I last saw her alive on Jan 15, 1937. Death is said to have occurred on the date stated above, at 4:00 p.m.

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

Chronic myocarditis
in Jan 1937
Date of onset

Other contributory causes of importance:

Name of operation

What test confirmed diagnosis

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?

Where did injury occur?

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

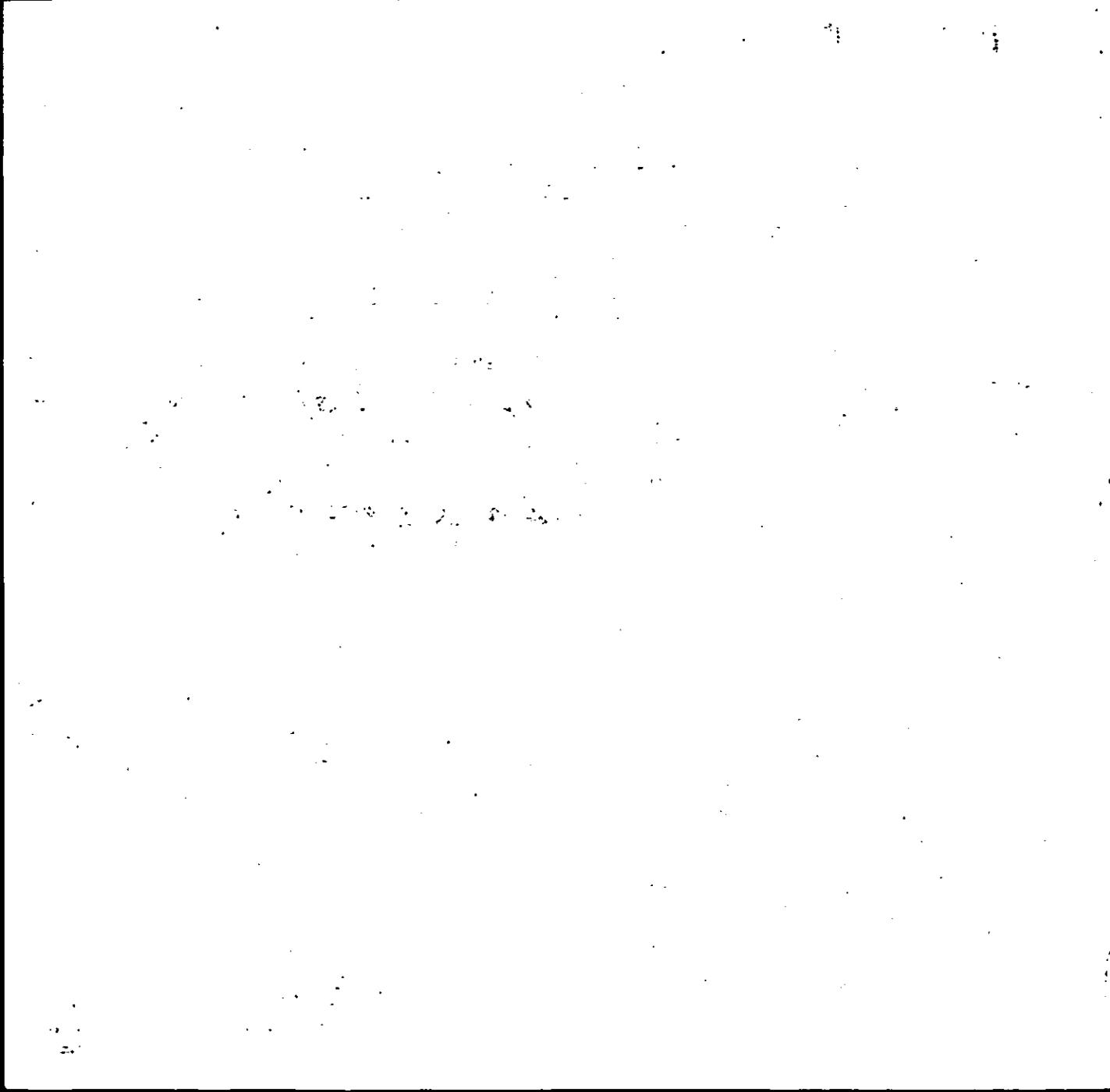
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) L A Haines, M. D.

(Address) Urbana, Mo.



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

14768-
Do not use this space.

1. PLACE OF DEATH

(a) County St. Charles Registration District No. 364
(b) Township Stark Primary Registration District No. 52-09 Registered No. 4
(c) City..... (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Elizabeth Brewster

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
89 7 5

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Home Home Ref
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME

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

MOTHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED June 14, 1938 J. M. Roberts Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 10, 1938

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... 19... 19...

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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) L. A. Glaser, M. D.

(Address) urpana mo

