

REC'D OCT 26 1938

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

33156
Do not use this space.

1. PLACE OF DEATH

(a) County St. Charles Registration District No. 757
(b) Township _____ Primary Registration District No. 3036 Registered No. 136
(c) City St. Charles (d) Street No. 322 S. Main St 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 14 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Write 2 - St. Charles 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 18 1938

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

22. I HEREBY CERTIFY, That I attended deceased from March 1937, to Sept 18 1938

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 5 1908

I last saw him alive on Sept 18 1938. Death is said to have occurred on the date stated above, at 11:30 P.M.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 30 8 13

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Dist. Factory
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) March 1938 11. Total time (years) spent in this occupation 14

Cardiac decompensation
Pneumonic heart disease
Chronic nephritis
Date of onset 9/10/38
1923
1935

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Perma Mo U.

Other contributory causes of importance: 10/1

FATHER 13. NAME Frank Brower

Name of operation none Date of _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lincoln Co. O

What test confirmed diagnosis? Exam + X-ray Was there an autopsy? no

MOTHER 15. MAIDEN NAME Bernis Lerschka

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

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lincoln Co. O

Where did injury occur? _____ (Specify city or town, county, and State)

17. INFORMANT (ADDRESS) Lillian Brower
322 S. Main

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove DATE Sept 21 1938

Manner of injury _____ Nature of injury _____

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Clough & Busch
424 1/2 E. Main St

24. Was disease or injury in any way related to occupation of deceased? no

20. FILED 9/21/38 19. Cloude S. Thayer Local Registrar.

(Signed) George E. Kister, M. D.
St. Charles, Mo. (Address)

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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 *Marion Munday*

Licensed Embalmer No. *2468*

P. O. Address *Hamling, Mo*

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, above space should be left blank.