

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8011

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis Children's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution two hours  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Monroe  
(c) City or town Rune, NR  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.R. # 2 Waterloo, Ill.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME EUGENE FRANK BREWER  
8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 24<sup>th</sup>  
year 1940 hour 11 minute 55 AM

4. Sex M. 5. Color or race Wh 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased January 3, 1940  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 24, 9:30 AM, 1940, to Sept 24, 11:55 AM, 1940; that I last saw him alive on Sept 24, 1940 and that death occurred on the date and hour stated above.  
Immediate cause of death Parenteral Acetosis Duration \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months 8 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Parenteral Diarrhea (non-specific)  
Due to \_\_\_\_\_  
Other conditions Otitis media  
(Include pregnancy within 3 months of death)

MOTHER FATHER  
12. Name Albert Brewer  
13. Birthplace Indianapolis Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Helene Kuchemeyr  
15. Birthplace Valmeyer Illinois  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Margaret Doe  
(b) Address 500 So. Kingshighway  
17. (a) Removal (b) Date thereof 9-24-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Valmeyer Ill.  
18. (a) Signature of funeral director August J. Hermann  
(b) Address Waterloo, Ill.  
19. (a) SEP 25 1940 (b) J. J. ...  
(Date of burial or cremation) (Signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on a farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Henry ... (M. D. or other) \_\_\_\_\_  
Address 500 So Kingshighway Date signed 9/25/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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

*J. S. Sullivan*

Licensed Embalmer No. 1122

P. O. Address \_\_\_\_\_

**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.**