

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

86777

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

9050

1. PLACE OF DEATH:

- (a) County St. Louis mo.
(b) City or town St. Louis mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: mo. Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3m days (Specify whether years, months or days)
In this community 3m days

3. (a) PRINT FULL NAME

Silas Brewington

8. (b) If veteran,

no

3. (c) Social Security

No. none

4. Sex

Male

5. Color or

race White

6. (a) Single, widowed, married,

divorced married

6. (b) Name of husband or wife

Lydia Brewington

6. (c) Age of husband or wife if

alive 27 years

7. Birth date of deceased

April

(Month)

(Day)

1884

(Year)

8. AGE:

Years

56

Months

6

Days

3

If less than one day

hr.

min.

9. Birthplace

Brunat

(City, town, or county)

mo.

(State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Napoliou Brewington

18. Birthplace

Missouri

14. Maiden name

Eliza Jackson

15. Birthplace

Missouri

16. (a) Informant's own signature

Marion Adler

(b) Address

8810 Lynnewood Ave.

17. (a)

Burial

(b) Date thereof

11-4-40

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Burkham mo.

18. (a) Signature of funeral director

Chas. O. Ball

(b) Address

445 Washington St.

19. (a)

NOV 2 1940

(b)

J. P. Budick

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Missouri

(b) County

(c) City or town

St. Louis mo.

(If outside city or town limits, write "RURAL")

(d) Street No.

N.R.

(If rural, give location)

(e) If foreign born, how long in U. S. A.?

years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month

October

day 30

year 1940

hour 2

minute 20 P.M.

21. I hereby certify that I attended the deceased from

10/27

1940 to

October 30, 1940

that I last saw him alive on

October 30, 1940

and that death occurred on the date and hour stated above.

Immediate cause of death

Cardiac decompensation and Hypertensive heart disease

Duration

3 weeks

3 weeks

Due to

Essential Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

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 farm, in industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

T. G. Blake

(M. D. or other)

Address

114 N. Taylor

Date signed 11/4/40

Margaret

11-50-77

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.....

Licensed Embalmer No.....

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.