

No. 2
13-40
17-39
X23159

FILED MAY 13 1949

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14591

318

Registration District No. _____

Primary Registration District No. 2001

Registrar's No. 367

1. PLACE OF DEATH
GREENE

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1709 ST. LOUIS ST.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether _____)
years, months or days

In this community _____
years, months or days

3. (a) PRINT FULL NAME OLIVE T. BREWER

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife James S. Brewer 6. (c) Age of husband or wife if alive 6 - 4 1/2 years

7. Birth date of deceased: Oct. 6 - 1902
(Month) (Day) (Year)

8. AGE: Years 38 Months 6 Days 24 If less than one day _____
hr. min.

9. Birthplace Springfield Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business In home

12. Name James Simon

13. Birthplace Unknown Ky.
(City, town, or county) (State or foreign country)

14. Maiden name Cheminthe
(State or foreign country)

15. Birthplace Unknown Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant James S. Brewer

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof May 2, 1949
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazwood Cem.

18. (a) Signature of funeral director W. E. Handley
(City, town, or county) (State or foreign country)

(b) Address Springfield, Mo.

19. (a) 5-2-41 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene

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

(d) Street No. 1709 St. Louis St
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1941 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from Nov 20, 1940
_____, 19____, to Apr. 30, 1941;
that I last saw her alive on Apr. 20, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death
Capillary aneurysm of uterus and adnexa
Due to primary uterus
Due to 48
Other conditions secondary aneurysm
(Include pregnancy within 3 months of death)

Duration
1 yr

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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?
9814
While at work? _____ (Specify type of place)
(e) Means of injury _____

Signature Arthur Knight (M.D. or other) MD
Address 450 1/2 E. Cass Date signed 5-1-41

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 *William Max Rhodes*

Licensed Embalmer No. *4071-*

P. O. Address *Springfield*

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, fact should be so stated above.