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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16933

FILED JUN 3 1944

Registration District No. ____ Primary Registration District No. 1002 Registrar's No. 2221

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2616 E. 6th St., /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community 37 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2616 E. 6th St.,
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME MYRON AUGUSTUS BREWSTER

3. (b) If veteran, name war 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 Ruth

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Dec. 24, 1887 (Month) (Day) (Year)

8. AGE: Years 56 Months 4 Days 27/28 If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Illinois / (State or foreign country)

10. Usual occupation Electrician

11. Industry or business Self

MOTHER FATHER
12. Name Augustus W. Brewster
13. Birthplace ____ (City, town, or county) Illinois / (State or foreign country)
14. Maiden name Belle C. Kirby
15. Birthplace ____ (City, town, or county) Illinois / (State or foreign country)

16. (a) Informant Ruth Brewster
(b) Address 2616 E. 6th St.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 23, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son,
(b) Address Kansas City

19. (a) 5-23-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21 year 1944 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h. alive on ____, 19____; and that death occurred on the date and hour stated above.
Deputy Coroner

Immediate cause of death Acute Carbon Monoxide — Duration
Due to Intoxication
Due to Running Car Motor.

Other conditions (Include pregnancy within 3 months of death) 63 M

Major findings:
Of operations
Of autopsy See Above

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) Suicide
(b) Date of occurrence May 21, 1944
(c) Where did injury occur? Kansas City Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? No (e) Means of injury Carbon Monoxide

23. Signature A. E. Asher M.D. (M. D. or other)
Address 28 McCoy Date signed 5/22/44

(Licensed Embalmer's Statement on Reverse Side)

APR 15 1955

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.