

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

8-43  
17-39  
X37823

Registration District No. 178

Primary Registration District No. 5668

State File No.

Registrar's No. 90

1. PLACE OF DEATH:

(a) County LEWIS

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

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) \_\_\_\_\_

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community all Her life years, months or days \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lewis

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

(d) Street No. 3 miles East Steffenville  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Clara Marie Brest

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12 year 1944 hour 2 minute 00 P M.

4. Sex Female 5. Color or race wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John Howard Brest 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Jan 14 1909  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 20 1944, to Sept 12 1944

that I last saw h. ER alive on Sept 12 1944 and that death occurred on the date and hour stated above.

8. AGE: Years 35 Months 7 Days 19 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Acute Septicemia (Puerperal) Duration 3 Mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace Canton, Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation Home wife

Other conditions Myocarditis 3 Mo  
(Include pregnancy within 6 months of death)

11. Industry or business \_\_\_\_\_

12. Name Clyde Goodwin

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

14. Maiden name Myrtle Mae Neaterson

15. Birthplace Keokuk, Ia. (City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings before death  
Pregnancy about 2 months before death

Of autopsy \_\_\_\_\_

16. (a) Informant Myrtle May Goodwin  
(b) Address Steffenville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Steffenville, Mo.

18. (a) Signature of funeral director Mrs. Baal  
(b) Address Curing, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's 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 farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

23. Signature Waldo Beason (M. D. or other) MD  
Address Rewark Mo Date signed 9/16/44

987

**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..... *Thomas Paal* .....

Licensed Embalmer No. *1744* .....

P. O. Address..... *Ewing, 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, fact should be so stated above.**

Registration District No. 178

Primary Registration District No. 5665

Registrar's No. 90

1. PLACE OF DEATH:

(a) County Leura  
 (b) City or town Hata Highland Township  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Clara Marie Burt

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased Jan 14 1900  
(Month) (Day) (Year)

8. AGE: Years 25 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Oct. 31, 1944 (b) P. H. Jennings, M.D.  
(Date received local registrar) (Registrar's signature) (cw)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 1944 year 1944 minute \_\_\_\_\_ M. 2

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

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

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTAL

IMMEDIATE

34630