

FILED FEB 17 1945

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 562

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: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days) unknown

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. 613 Main
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George 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 unm
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased unknown
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 4
year 1945 hour 7 minute 40 A.M.
21. I hereby certify that I attended the deceased from January 31 1945 to February 4 1945
that I last saw him alive on February 4 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
66 hr. min.

Immediate cause of death Prostatic hypertrophy with uremia
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) 137a

9. Birthplace Not known (City, town, or county) (State or foreign country) 9
10. Usual occupation Not known
11. Industry or business Not known
12. Name Not known
13. Birthplace Not known (City, town, or county) (State or foreign country) 49
14. Maiden name Not known
15. Birthplace Not known (City, town, or county) (State or foreign country) 7

Major findings: Of operations _____
Of autopsy None
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Record Clerk
(b) Address General Hospital No. 1
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-5-45
(Month) (Day) (Year)
(c) Place: burial or cremation Lawrence, Kan.
18. (a) Signature of funeral director Geo. M. Callier
(b) Address Indep. Mo
19. (a) 2-15-45 (Date received local registrar) (b) T. E. Brown (V3) (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) _____
(e) Manner of injury? no
23. Signature Clark Wisely (M. D. or other) no D
Address Med. Dir. Gen'l Hosp. Date signed 2-5-45

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 Geo M. Callier

Licensed Embalmer No. 3839

P. O. Address Indep 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.