

FILED APR 27 1945

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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 11036

3453

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 18 days  
(Specify whether  
In this community Unk.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5800 Arsenal  
(If rural, give location) 13  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

William Brewer

(b) If veteran, name war no

(c) Social Security No. none

4. Sex M Color or race N  
5. Color or race N  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Josephine Brewer  
6. (c) Age of husband or wife if alive 52 years  
7. Birth date of deceased Jan 16 1892  
(Month) (Day) (Year)

8. AGE: Years 53 Months 2 Days 28  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Blument Colo. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Labourer

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

12. Name George Brewer  
13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah  
15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Josephine Brewer  
(b) Address 1806 N Leffingwell  
17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oakdale Cem

18. (a) Signature of funeral director J. H. Harrison  
(b) Address 2906 Newton

19. (a) APR 12 1945 (b) J. F. Bredeh  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14,  
year 1945 hour 1 minute 55 P.M.

21. I hereby certify that I attended the deceased from March  
27, 19 45 to April 14, 19 45  
that I last saw him alive on April 14, 19 45  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Hypertensive degenerative heart disease with congestive failure

Due to \_\_\_\_\_  
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 0

23. Signature B. F. Murphy (M. D. number) \_\_\_\_\_  
Address 2601 White Date signed 4/16/45

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

MOTHER FATHER

**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 *Arthur L. Hilliard*

Licensed Embalmer No. *4221*

P. O. Address *1154 Bayard*

**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.**