

FILED SEP 7 1945

Registration District No. **260**

Primary Registration District No. **6225**

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Rural Warbler Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution State Hospital No 3 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo. 21 da.
In this community Same time
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. R. F. D. 71
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Madison Andrew Brewer
3. (b) If veteran, name war. No 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 8
year 1945 hour 11:30 minute P. M.
21. I hereby certify that I attended the deceased from May 18
1945, 19____, to Aug. 8 - 1945, 19____;
that I last saw him alive on Aug. 18 - 1945, 19____;
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Wid.
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive unk. years
7. Birth date of deceased Unknown
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis
Duration _____
Due to Generalized Arteriosclerosis.
Due to _____

8. AGE: Years 76 Months _____ Days _____ If less than one day _____ hr. _____ min.

Other conditions: (Include pregnancy within 3 months of death) _____
Major findings: 92d
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Farming
11. Industry or business Farm
12. Name Unknown
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 Hospital Records
(b) Address Nevada mo.
17. (a) Removal (b) Date thereof 8-8-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Springfield, Mo.
18. (a) Signature of funeral director Alvin N. Johnson
(b) Address Springfield, Mo.
19. (a) 8-8-45 (b) Harold B. Beurek
(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) (e) Means of injury "
23. Signature R. B. Rester (M. D.)
Address Nevada mo. Date signed 8-8-45

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

RECEIVED

District Health Officer No: 71

District File Number 8-45-821

Date Filed 9-5-45

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

Marsh. Eubinger

Licensed Embalmer No. *2656*

P. O. Address. *Quail, 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.