

**1. PLACE OF DEATH:**  
 (a) County Greene  
 (b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution 1907 North Jefferson 1  
(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 10 years

**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. 1907 North Jefferson  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** JOHN J. BREW  
 3. (b) If veteran, name war no.  
 3. (c) Social Security No. 493-16-3763

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Martha  
 6. (c) Age of husband or wife if alive 53 years  
 7. Birth date of deceased Sept 17 1886  
(Month) (Day) (Year)

**8. AGE:** Years 60 Months 4 Days 1  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Painter  
 11. Industry or business Painter

12. Name William J. Brew  
 13. Birthplace England  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Martha Brew  
 (b) Address 1907 N. Jefferson  
 17. (a) Burial (b) Date thereof 1-23-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Queen Lawn

18. (a) Signature of funeral director W. H. Kingman & Co.  
 (b) Address Springfield, Mo.  
 19. (a) 1-18-47 (b) W. H. Kingman MD  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month January day 18  
 year 1947 hour \_\_\_\_\_ minute 8:00 A.M.

21. I hereby certify that I attended the deceased from July, 1946 to 1-19, 1947  
 that I last saw h. alive on 12-27, 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebro-renal vascular  
Disease

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) Mechanism of injury \_\_\_\_\_

23. Signature Max T. [unclear] (M. D. or other) MD  
 Address Springfield, Mo. Date signed 1-18-47

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

*Ogle Stone Jr.*

Licensed Embalmer No.

*4176*

P. O. Address

*Springfield*

**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.**