

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24129
Registrar's No. 6420

Registration District No. 318

Primary Registration District No. 1003

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.....
St. Louis City Hospital - Max C. Starkloff
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri**..... (b) County..... **ADO**
(c) City or town..... **St. Louis**.....
(If outside city or town limits, write "RURAL")
(d) Street No. **3414 1/2 North 14th St.**
Memorial
(If rural, give location)
(e) Citizen of foreign country?.....
If yes, name country.....

3. (a) PRINT FULL NAME..... **JAMES BREWER**
3. (b) If veteran, name war.....
3. (c) Social Security No.

4. Sex..... **Male**..... 5. Color or race..... **White**
6. (a) Single, widowed, married, divorced..... **Married**
6. (b) Name of husband or wife..... **Barbara L. Brewer**
6. (c) Age of husband or wife if alive..... **72** years
7. Birth date of deceased..... **Jan. 6th. 1866**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 6 12 hr. min.

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

10. Usual occupation..... **Cook**

MOTHER FATHER

11. Industry or business.....
12. Name..... **Unknown**
13. Birthplace..... **Unknown**
(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..... **Barber L. Brewer - Wife**
(b) Address..... **3414 1/2 North 14th St.**

17. (a)..... **Burial**..... (b) Date thereof..... **7/21/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Memorial Park Cem.**

18. (a) Signature of funeral director..... **Sullivan Funeral Dir.**

(b) Address..... **2849 North Euclid Ave.**

19. (a)..... **JUL 20 1948**..... (b)..... **J. D. Bradock**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **July**..... day..... **18th**
year..... **1948**..... hour..... **6**..... minute..... **20 P M.**

21. I hereby certify that I attended the deceased from..... **7/17/48**
..... 19..... to..... **July 18th**..... 19..... **48**
that I last saw him alive on..... **July 18th**..... 19..... **48**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Pulmonary Tuberculosis

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

Duration
PHYSICIAN
Underline the cause of 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?.....
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... **John Heider**.....
1315 Lafayette..... (City or town) (County) (State)

Address..... Date signed.....

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

Robert L. Brinkman

Licensed Embalmer No. *3553*

P. O. Address.....

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.