S. No. 300
v. 10.48

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8036

State File No.

BIRTH NO. REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 236-A

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield
c. LENGTH OF STAY (In this place): 15 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 935 - S. Grant

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Greene
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield
d. STREET ADDRESS (If rural, give location): 935 S. Grant

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): PORTER
c. (Last): BREWER

4. DATE OF DEATH (Month) (Day) (Year): Mar 10 49

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 24 - 1895
9. AGE (In years last birthday): 54
IF UNDER 1 YEAR: Months / Days
IF UNDER 1 HR.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: All jobs
11. BIRTHPLACE (State or foreign country): Springfield Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: James Brewer
13b. MOTHER'S MAIDEN NAME: Tishia Johnson
14. NAME OF HUSBAND OR WIFE: Hazel Brewer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Hazel Brewer
ADDRESS: 935 Grant

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 5 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cirrhosis of Liver
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 19, 1949, *to* Mar. 10, 1949, *that I last saw the deceased alive on* Feb. 26, 1949, *and that death occurred at* 6:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lyman D. Brown M.D.
23b. ADDRESS: 311½ Boonville
23c. DATE SIGNED: Mar. 12, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-13-49
24c. NAME OF CEMETERY OR CREMATORY: Hazlewood
24d. LOCATION (City, town, or county) (State): Springfield Mo

DATE REC'D BY LOCAL REG.: 3/14/49
REGISTRAR'S SIGNATURE: W.S. Handley M.D.
25. FUNERAL DIRECTOR'S SIGNATURE: H.V. Smith
ADDRESS: 602 N. Jefferson

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____, Student Embalmer No. _____, working under my personal supervision.

Student ..... Student Embalmer

Signed Herbert V Smith

Licensed Embalmer No. 4286

P. O. Address Springfield K

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.