

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5870

No. 300
10-48

FILED JUL 15 1949

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY <i>Mad</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 27-1006 a N. Leffingwell Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Josephine b. (Middle) c. (Last) Brewer	4. DATE OF DEATH (Month) (Day) (Year) July 2 1949
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5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 15, 1887	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) South Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Myrtle Miller, ADDRESS 1419 N. Spring Ave.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		1 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Heart Disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Urethral Stricture			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <i>90</i>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>HH 3 X</i>
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22. I hereby certify that I attended the deceased from 6-3, 1949, to 7-2, 1949, that I last saw the deceased alive on 7-2, 1949, and that death occurred at 7:50 am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>H. D. Thompson M. D.</i>	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 7-5-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-9-1949	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
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DATE REC'D BY LOCAL REG. JUL 6 1949	REGISTRAR'S SIGNATURE <i>J. B. L...</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, 2820 Stoddard St.
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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

Fulton E. Culkin

Licensed Embalmer No. *498*

P. O. Address

Paris 13 W

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.