

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24636

1003 State File No. 6392

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. _____ REGISTRAR'S NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (In this place) 45 yrs		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1819a Chouteau Avenue		d. STREET ADDRESS (If rural, give location) 222 1819a Chouteau Avenue	

3. NAME OF DECEASED (Type or Print)	a. (First) SUSAN	b. (Middle) WESCOTT	c. (Last) BREWER	4. DATE OF DEATH (Month) (Day) (Year) July 20 1949
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W 2	8. DATE OF BIRTH May 26, 1861	9. AGE (In years last birthday) (If under 1 year: Months) (If under 24 hrs: Days) (Hours) (Min.) 88 1 24
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Dye	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Charles
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Lillian Lindsley	ADDRESS 1819a Chouteau 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>indefinite</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	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) <u>97</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>with</u>
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22. I hereby certify that I attended the deceased from July 9, 1949, to July 20, 1949, that I last saw the deceased alive on July 9, 1949, and that death occurred at 7:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Don C. Hale</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>1504 So. Grand Blvd</u>	23c. DATE SIGNED <u>7-23-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-23-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>National</u>	24d. LOCATION (City, town, or county) (State) <u>Jeff. Bks. Mo</u>
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DATE REC'D BY LOCAL REG. <u>JUL 23 1949</u>	REGISTRAR'S SIGNATURE <u>J. B. Pasater</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. McLaughlin</u>	ADDRESS <u>2301 Lafayette</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6889

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 L R Cooper

Licensed Embalmer No. 3633

P. O. Address 2301 Lafayette Ave

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.