

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29254

STATE FILE NUMBER

FILED AUG 26 1957

318

1003

Registral's No. 7312

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 City Hospital			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 21 3223 Laclede Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Samuel Middle Brewster Last Brewster			4. DATE OF DEATH Month August Day 1 Year 1957				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 25, 1932		9. AGE (In years last birthday) 25	IF UNDER 1 YEAR Months 5 Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Brewster				14. MOTHER'S MAIDEN NAME Amanda Griffin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 500-24-1793		17. INFORMANT Address Amanda Griffin 3223 Laclede			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage; Subdural Hemorrhage; Fracture of Ribs; E9028 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Suffered in fall from scaffold while working in the rear of 39th Street, about 12:55 p.m. DUE TO (c) Suffered in fall from scaffold while working in the rear of 39th Street, about 12:55 p.m. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. *DESCRIBE ANY INJURY OCCURRED (Enter nature of injury in Part I, but not in Part II) fracture of ribs		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY 12:55 p.m. 8/1/57		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 18		20e. CITY, TOWN, OR LOCATION St. Louis Mo		20f. COUNTY STATE	
21. I attended the deceased from 11:2 P. to 11:2 P. and last saw her alive on 8/5/57 . Death occurred at 11:2 P. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Patrick Taylor Carand				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 8-5-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8/6/57	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		
24. FUNERAL DIRECTOR ADDRESS Wm. Smith 4019 Washington Blvd.				25. DATE RECD. BY LOCAL REG. AUG 5 57		26. REGISTRAR'S SIGNATURE J. Carl Smith Mo	

(Licensed Embalmer's Statement on Reverse Side)

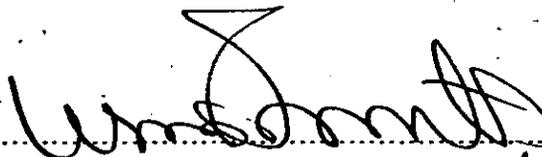
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4

P. O. Address St. La

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.