

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 10 1960

-60-034254

STATE FILE NUMBER

Registration District No. 82 Primary Registration District No. 5308 Registrar's No. 143

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Blackwater township</u>		Length of stay in 1b <u>3 1/2</u> years		c. CITY OR TOWN <u>Blackwater township</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rural route, Blackwater</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rural route, Blackwater</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Friedrich</u> Middle <u>Edward</u> Last <u>Brewe</u>				4. DATE OF DEATH Month <u>October</u> Day <u>4th</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>II-24-1875</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Rineland, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>William Brewe</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Klusmeyer</u>			14. NAME OF HUSBAND OR WIFE -----		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) -----			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Julius Brewe, Arrow Rock Mo.</u> Address -----			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Pneumonia - (Bronchial)</u>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) _____								
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <u>Oct 1-60</u> , to <u>Oct 4-60</u> and last saw him alive on <u>Oct 4-60</u> . Death occurred at <u>3-50 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>John R. Lawrence M.D.</u> (Degree or title)				22b. ADDRESS <u>Marshall Mo</u>			22c. DATE SIGNED <u>10-4-60</u>	
23a. BURIAL, CREMATION, REMOVAL. (Specify) <u>Burial</u>		23b. DATE <u>10-6-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arrow Rock cemetery</u>		23d. LOCATION (City, town, or county) <u>Arrow Rock Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Campbell-Lewis, Marshall Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>10/5/60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James H. Lewis

Licensed Embalmer No. 4709

P. O. Address Marshall

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.