

JUL 27 1926

over

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

✓ 19025

1. PLACE OF DEATH

County Carroll Registration District No. 135
Township _____ Primary Registration District No. 3010
City Carrollton (No. _____) _____ St. _____ Ward _____

File No. _____
Registered No. 49
St. _____ Ward _____

2. FULL NAME Herman Palmare Brewer

(a) Residence No. Waverly Missouri St. Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. _____ mos. _____ ds. _____ How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____ (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>ms H P. Brewer</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 6, 1897</u>		
7. AGE	YEARS <u>29</u>	MONTHS <u>2</u>
	DAYS <u>22</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) <u>Lafayette County</u> (STATE OR COUNTRY)		

PARENTS	10. NAME OF FATHER <u>Henry Brewer</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Warren County Mo.</u>
	12. MAIDEN NAME OF MOTHER <u>Caroline Fischer</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Warren County Mo.</u>

14. INFORMANT Henry Brewer
(Address) Waverly Mo.

15. FILED 6-29-1926 ms E. E. Farnham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28 1926
17. I HEREBY CERTIFY That I attended deceased from April 27, 1926 to June 28, 1926 that I last saw him alive on June 28, 1926 and that death occurred, on the date stated above, at 1:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Multiple abscesses of liver
(duration) _____ yrs. _____ mos. 65 ds.
CONTRIBUTORY Appendicitis
(SECONDARY)
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF _____ May 1st 26
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Subsequent operation
(Signed) H. H. Cook M. D.
6/29, 1926 (Address) Carrollton Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Waverly Mo.</u>	DATE OF BURIAL <u>6/30 1926</u>
20. UNDERTAKER <u>Wills Boo</u>	ADDRESS <u>Carrollton Mo.</u>

WRITE PLAINLY, WITH UNFADING INK...THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of———(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull; and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Carroll Registration District No. 135 File No. _____
 Township _____ Primary Registration District No. 2010 Registered No. P 49
 City Carrollton (No. Palmore Herman Julius Brew Ward)

2. FULL NAME

Herman Palmore Brew
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work mechanic
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Was the abscess tuberculous or due to other infection or traumatic? If traumatic please state kind of accident. Please sign and return.
Please note other changes

(STATE OR COUNTRY)

14. INFORMANT Henry Brew
 (Address) Malta Bend Mo

15. FILED 6-29-26 Mrs E E Farham
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28 19 26

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____, 19____, P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

multiple abscesses of liver
secondary to
ruptured appendix
 (duration) yrs. mos. da.
 CONTRIBUTORY appendicitis
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH DATE OF

THERE AN AUTOPSY

TEST CONFIRMED DIAGNOSIS

(Signed) _____, M. D.

, 19 (Address)

in the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state

(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

LAW

REGISTRARS SH

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BY PHYSICIAN.

S(2)19025

AMERICA
MISOURI

RECEIVED FOR BINDING

may be legally distributed

MEMBERS
Chairman
Chairman
Treasurer
Secretary

SALINE MISSOURI
THE AMERICAN
MARSHALL, MISSOURI

FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PREPARED
Call
H. C. Rawlings Home Service
Dr. F. A. Howard, Slater, First Aid

September 1, 1931

RECEIVED
SEP 1 1931
THE STATE DEPARTMENT OF HEALTH
OF MISSOURI

Bureau of Vital Statistics,
Jefferson City, Missouri.

Gentlemen:

I am here inclosing the certified copy of your records, #5593, as to the death of one Herman Palmore Brewe, together with an affidavit of one Jessie E. Weinreich, showing the correct spelling of the name of this deceased; and it is requested that your records be changed to show the correct name of this deceased as being Palmore Herman Julius Brewe. If further affidavits or proof is necessary please advise me.

It is requested that you furnish us with a certified copy of your records as corrected, showing the death of this veteran for such proof is necessary in the proper presentation of certain claims now being prepared and forwarded to the United States Veterans Bureau.

Very truly yours,

Owen C. Rawlings

Owen C. Rawlings
Chairman, Home Service, A.R.C.