

Registration District No. 1003

Primary Registration District No. \_\_\_\_\_

Registrar's No. 11041

1. PLACE OF DEATH:

(a) County 1  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri Baptist Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 week  
In this community 624 Lynch St. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1  
(c) City or town St. Louis 24  
(If outside city or town limits, write "RURAL")  
(d) Street No. 624 Lynch St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 24  
year 1939 hour 10 minute 30a. M.

21. I hereby certify that I attended the deceased from Dec - 12, 1939 to Dec. 24, 1939;  
that I last saw him alive on Dec 24, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
acute parenchymatous hepatitis (amoebic) 9 days  
Due to toxilitis & pharyngitis non aliphatic 15 days  
Due to \_\_\_\_\_

Other conditions malnutrition and anemia  
(Include pregnancy within 3 months of death)  
Major findings: 1 1/2  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. R. Mum (M. D. or other) \_\_\_\_\_  
Address 2227 S. Broadway Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Eugene Brewster 62

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 8, 1935  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
4 4 16 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Unknown Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Daniel Brewster

13. Birthplace Unknown Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Ollie May Johnson

15. Birthplace Unknown Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Daniel Brewster

(b) Address 624 Lynch St.

17. (a) Burial (b) Date thereof 12/27/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director Wacker-Welder

(b) Address 2331 S. Broadway

19. (a) DEC 27 1939 (b) J. J. Brudick  
(Date received local registrar) (Registrar's signature)

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.

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Robert Wheeler

Licensed Embalmer No. 2178

P. O. Address St Louis Mo

**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, above space should be left blank.**