

Registration District No. 384

Primary Registration District No. 55351

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Hawaii  
(b) City or town West Hawaii mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Howell Top!  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 32 yrs (Specify whether  
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Hawaii  
(c) City or town West Hawaii 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. F. D. 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Mary Tracie Brewer

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

4. Sex 71 5. Color or race w 6. (a) Single, widowed, married, divorced mi

6. (b) Name of husband or wife Rayd Brewer 6. (c) Age of husband or wife if alive 21 years

7. Birth date of deceased Dec-2-1908  
(Month) (Day) (Year)

8. AGE: Years 32 Months 2 Days 26 If less than one day hr. min.

9. Birthplace Hawaii Co, mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Chas. Gardner

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

14. Maiden name Anna Kagan

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

16. (a) Informant Rayd Brewer

(b) Address West Hawaii mo

17. (a) B- (b) Date thereof 3-29-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Howell Top

18. (a) Signature of funeral director Kaplan and

(b) Address West Hawaii mo

19. (a) 4-5-41 (b) Vida W SIMONS  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 28  
year 1941 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb 15  
1941 to March 28, 1941.  
that I last saw him alive on March 27, 1941.  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations None

Of autopsy None

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? \_\_\_\_\_

344 (Specify type of place) While at work? \_\_\_\_\_

28. Signature [Signature] (M. D. or other) [Signature]

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 5,

District File Number

54116.09

Date Filed \_\_\_\_\_

**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 \_\_\_\_\_

*Wap*  
working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed

*Raymond J. Kabeutis*

Licensed Embalmer No. *3435*

P. O. Address *West Haven,*

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.