S. No. 2
1—5-42
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6040

Registration District No. 59 | Primary Registration District No. 4097 | Registrar's No. 38

1. PLACE OF DEATH:
(a) County: Cass
(b) City or town: Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 days (Specify whether years, months or days)
In this community: 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Cass
(c) City or town: Harrisonville
(If outside city or town limits, write "RURAL")
(d) Street No.:
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Margaret Thelma Brewer
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: —
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Charles O. Brewer
6. (c) Age of husband or wife if alive: 31 years
7. Birth date of deceased: April 14 1918 (Month) (Day) (Year)

8. AGE: Years 24 | Months 9 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace: Kansas City (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Beauty Operator
11. Industry or business:
MOTHER FATHER
12. Name: Robert Wallace
13. Birthplace: Mo (City, town, or county) 0 (State or foreign country)
14. Maiden name: Mary Leland Bailey
15. Birthplace: Mo 0 (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Leland Elkins
(b) Address: Harrisonville Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/12/43 (Month) (Day) (Year)
(c) Place: ~~burial or cremation~~ Orient Cemetery
18. (a) Signature of funeral director: RUNNENBURGER'S
(b) Address: HARRISONVILLE MO.
19. (a) Feb. 12-1943 (Date received local registrar) (b) Margaret Tolle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 10 day ____ year 1943 hour 12 minute 0'clock P. M.
21. I hereby certify that I attended the deceased from — , 19____, to ____, 19____;
that I last saw h— alive on — , 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Shock died while recovering from a Caesarean Operation
Due to: Pressure from Shock
of Hemorrhage
Due to: ✓
Other conditions (Include pregnancy within 3 months of death): Pregnancy full Term
Major findings: Of operations: Caesarean Operation
Of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: E. M. Griffith (M.D. ~~or other~~)
Address: Harrisonville Mo Date signed 2/12/43

1041 (Licensed Embalmer's Statement on Reverse Side) Coroner Cass Co

AUG 19 1950

MAY 22 1947

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 Ernest Reinnenburger

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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, fact should be so stated above.

V. S. No. 2B
10M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6040

Registration District No. ____ Primary Registration District No. 4097 Registrar's No. ____

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

1. PLACE OF DEATH:
(a) County: Cass
(b) City or town: Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 da (Specify whether years, months or days)
In this community: 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Cass
(c) City or town: Harrisonville
(If outside city or town limits, write "RURAL")
(d) Street No.: —
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Margaret Thelma Brewer
3. (b) If veteran, name war: —
3. (c) Social Security No.: —

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: Charles C
6. (c) Age of husband or wife if alive: 31 years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 24 Months 9 Days 6 If less than one day: hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation:
11. Industry or business:
MOTHER FATHER
12. Name:
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name:
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant:
(b) Address:
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation:
18. (a) Signature of funeral director:
(b) Address:
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day ____ Year 1943 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from ____ 19__ to ____ 19__; that I last saw him alive on ____ 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Shock died while undergoing a caesarian operation probably from shock or not	
Due to: there was a delivery after death immediately	
Other conditions: after (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 1496
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury:
23. Signature: C M Guffith (M. D. or other)
Address: Harrisonville Mo Date signed: 3/19/42
Coroner Cass Co

SUPPLEMENTARY