

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 19 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3006

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, print "RURAL" and name of township)
(c) Name of hospital or institution: 2030 Kensington 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Clifford Earl Brewer

3. (b) If veteran, name war No 3. (c) Social Security No. 487-01-8488

4. Sex SM 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Glady's 6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased June 25 - 1907
(Month) (Day) (Year)

8. AGE: Years 36 Months 0 Days 11 If less than one day hr. min.

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

10. Usual occupation Unemployed Steel

11. Industry or business Steel

12. Name Clifford Earl Brewer

13. Birthplace Linn Co. Mo. (City, town, or county) (State or foreign country)

14. Maiden name Bertie May

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

16. (a) Informant Mrs. Gladys Brewer

(b) Address 2030 Kensington

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-1943 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs. C. H. Fowler

(b) Address H. G. Mo.

19. (a) 7-7-43 (Date received local registrar) (b) H. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 2030 Kensington (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5 year 43 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 5 - 43 to July 5 - 43 that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis One Day

Due to 94a

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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) (f) Means of injury _____

23. Signature R. L. St. Clair (M. D. or other) Address 524 2 St. Clair Date signed July 6

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

5242
John