

FILED NOV 3 1944

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **9087**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **9 1/2 Hrs.** **0**
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **22 S. Theresa**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Claudia Mae Brewer**

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

4. Sex **Female** **3** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **0**

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

7. Birth date of deceased **8 12 44**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **12**
 year **44** hour **4** minute **00** pm.

21. I hereby certify that I attended the deceased from **8 - 12**
 _____, 19**44** to **8 - 12**, 19 **44**
 that I last saw h. **er** alive on **8 - 12**, 19 **44**
 and that death occurred on the date and hour stated above.

8. AGE:

| Years | Months | Days | If less than one day |
|-------|--------|------|----------------------|
| | | | 9 hr. 30 min. |

Immediate cause of death **Prematurity** *Duration*

Due to **Unknown**

Due to **Unknown** **159**

Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace **St. Louis** **0** **Missouri**
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings:
 Of operations _____
 Of autopsy _____

Underline the cause to which death should be charged statistically.

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name **Weona Brewer nee Wilkerson**
(State or foreign country)

15. Birthplace **Little Rock** **1** **Arkansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary T. Duwall**

(b) Address **2601 N. Whittier Street**

17. (a) **Burial** (b) Date thereof **OCT 26 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CITY CEMETERY**

18. (a) Signature of funeral director **B. Ruden**

(b) Address **City Health Dept.**

19. (a) **OCT 26 1944** (b) **J. Fredrick**
(Date received local registrar) (Registrar's signature)

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? _____ (c) Means of injury _____

23. Signature **M. S. Siskler** (M. D. or other) _____

Address **2601 N. Whittier St.** Date signed _____

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

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.