

FILED **SEP 21 1946**

1000

1165

Registration District No. **42**

Primary Registration District No.

Registrar's No.

## 1. PLACE OF DEATH

(a) County Buchanan  
 (b) City or town St. Joseph  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: E. Flanagan Nursing Home 2018 Francis  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 35 days  
 (Specify whether years, months or days) 71 yrs

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew Co  
 (c) City or town Rosendale  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. RURAL  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CLAUDENE BREWER

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

4. Sex female! 5. Color or race white  
 6. (a) Single, widowed, married, divorced m  
 6. (b) Name of husband or wife Caroden Brewer 6. (c) Age of husband or wife if alive 40 years  
 7. Birth date of deceased Oct 5 1905  
 (Month) (Day) (Year)

8. AGE: Years 41 Months - Days 11  
 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business Housewife12. Name Walter Mackey13. Birthplace un known mo  
 (City, town, or county) (State or foreign country)14. Maiden name Bess Bowman15. Birthplace un known mo  
 (City, town, or county) (State or foreign country)16. (a) Informant Caroden Brewer17. (a) Address Rosendale mo17. (c) B. (b) Date thereof 10-18-1946  
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Bolckow18. (a) Signature of funeral director E. G. Breit19. (a) Oct. 18, 1946 (b) E. J. [unintelligible]  
 (Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16  
 year 1946 hour 6 minute 10 A. M.

21. I hereby certify that I attended the deceased from Sept 13  
1946 to Oct 15 1946  
 that I last saw her alive on Oct 15 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Disseminated Sclerosis  
(DISSEMINATED) Duration 4 yrs

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

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

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

Major findings:  
 Of operations r

Of autopsy r

ADDITIONAL  
 SUPPLEMENTARY  
 INFORMATION

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: (D)

(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? r (Specify type of place) \_\_\_\_\_  
 (e) Means of injury 0

23. Signature of physician Charles H. Werner (M. D. or other)  
 Address 325 Kirkpatrick Bldg 1077-1946

**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 E. C. Breit

Licensed Embalmer No. 2630

P. O. Address Savannah 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.**

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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 Claudene 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 \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 5 1901  
(Month) (Day) (Year)

8. AGE: Years 41 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
Year 1942 Hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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: Disseminated Sclerosis Duration 4 yrs

Due to: Toxic or Infective agent 4 yrs

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

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

Major findings: Of operations \_\_\_\_\_

Of autopsy: 87D

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Charles H. Werner (M. D. or other) \_\_\_\_\_  
221 Kirkpatrick Bldg Date signed 1942

SUPPLEMENTARY

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

31571

32742