

Registration District No. **170**

Primary Registration District No. **3033**

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

3
1
2

1. PLACE OF DEATH:

(a) County Letcher

(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Wallace Memorial Hospital Lebanon
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 hours 0
(Specify whether years, months or days)

In this community 20 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Clarence Brewer

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased January 5, 1874
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 2 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business farming

MOTHER FATHER

12. Name Joseph F Brewer

13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Sarah McLaughlin

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

16. (a) Informant Mrs. Larene Burnett

(b) Address Kansas city Mo

17. (a) burial (b) Date thereof 12-9-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Vaughn Cemetery

18. (a) Signature of funeral director Stouland Mo

(b) Address 12-14-46

19. (a) 12-14-46 (b) Ora Frankburger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Letcher

(c) City or town Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7th
year 1946 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from Aug 15th 1946 to Dec 7th 1946; that I last saw him alive on Dec 7th 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Valvular disease of the heart

Due to _____

Due to _____

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

Major findings: Of operations 92nd

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) (e) Means of injury _____

23. Signature C. G. Cantor (M. D. or other) 0
Address Stouland Mo Date signed 12-9-46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Received 12/17/46
Laclede County Health Unit
File No. 12-46-172
Date Filed 12/17/46

JAN 9 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 *Dorsey M Howe*

Licensed Embalmer No. *4222*

P. O. Address *Lebanon 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.