

No. 300  
-10-47  
5-17-39  
1-3908

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41306  
State File No. \_\_\_\_\_  
Registrar's No. 10998

FILED JAN 11 1949 318  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1438a Warren St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 24 years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ben. Brewer  
3. (b) If veteran, name war none.  
3. (c) Social Security No. none.

4. Sex male  
5. Color or race white  
6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Ola Brewer  
6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased December 27th, 1884 (Month) (Day) (Year)

8. AGE: Years 63, Months 11, Days 21, If less than one day hr. min.

9. Birthplace Tennessee (City, town, or county) (State or foreign country)  
10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_  
12. Name Thomas Brewer  
13. Birthplace Tennessee (City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Krick  
15. Birthplace Tennessee (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ola Brewer  
(b) Address 1438a Warren St.  
17. (a) Burial (b) Date thereof 12-21-48 (Month) (Day) (Year)  
(c) Place: burial or cremation Lake Charles Cem.  
18. (a) Signature of funeral director Hy. Leidner U. Co.  
(b) Address 2223 St. Louis Ave.  
19. (a) DEC 20 1948 (Date received local registrar) (b) J. B. Spater (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1438a Warren St. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month December 18th  
year 1948 hour 3:45 PM minute M.

21. I hereby certify that I attended the deceased from Dec. 16, 1948 to Dec. 18, 1948, that I last saw him alive on Dec 17, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure  
Due to Chronic myocarditis  
Other conditions Undulant fever  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Duration 1 wk.  
2 yrs  
2 yrs

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) (c) Means of injury \_\_\_\_\_  
23. Signature J. C. Creane (M. D. or other)  
Address 2504 N. 14th St Date signed Dec 24

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**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 *J. Allen Davis*.....

Licensed Embalmer No. *4053*.....

P. O. Address. *2223 St. Louis A*.....

**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. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town \_\_\_\_\_  
(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)

3. (a) PRINT FULL NAME Ben Bremer

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife ela

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 27 1948  
(Month) (Day) (Year)

8. AGE: Years 63 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 \_\_\_\_\_

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

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

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

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

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

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1948 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 \_\_\_\_\_

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

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

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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

S-41306

Ch-16524