

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-847105  
STATE FILE NUMBER

Registration District No. 172 Primary Registration District No. 5567 Registrar's No. 5

FILED JAN 19 1959

1. PLACE OF DEATH a. COUNTY <b>Howell</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howell</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sisson Twp.</b>		c. CITY OR TOWN <b>Sisson Twp. Pomona</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>res</b>		d. STREET ADDRESS (If outside, give location) <b>Pomona, Mo., R-2</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb <b>16 yrs</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>30</b> Year <b>1958</b>	
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>KEZIA</b> Last <b>BREWER</b>		5. SEX <b>female</b> 6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 14, 1866</b> 9. AGE (In years last birthday) <b>92</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <b>Des Moines, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>William Stover</b>		13b. MOTHER'S MAIDEN NAME <b>Parkhurst</b>	
14. NAME OF HUSBAND OR WIFE <b>John F. Brewer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs John McFarland, R-2, Pomona, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>10 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>12/27/58</u> to <u>12/30/58</u> and last saw her alive on <u>12/27/58</u> Death occurred at <u>3:30 pm</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>M. L. Fowler MD</b>		22b. ADDRESS <b>West Plains Mo</b>	
22c. DATE SIGNED <b>1/9/59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	
23b. DATE <b>Jan. 2, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23d. LOCATION (City, town, or county) <b>West Plains, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Hal Shoumough</b> ADDRESS <b>CARTER FUNERAL HOME WEST PLAINS, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>1-13-1959</b>	
26. REGISTRAR'S SIGNATURE <b>Laura Mitchell</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Hal Johnson* .....

Licensed Embalmer No. *340* .....  
CARTER FUNERAL HOME  
P. O. Address ..... WEST PLAINS, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.