

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012340

STATE FILE NUMBER

FILED MAY 4 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 427

300  
-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Andrew	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN Rosendale 6020	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL Missouri Methodist		d. STREET ADDRESS (If outside, give location) 4 miles west	
3. NAME OF DECEASED (Type or print) CHARLES BREWER		4. DATE OF DEATH Month Day Year April 23, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm	11. BIRTHPLACE (City and state or country) Rosendale, Missouri
13a. FATHER'S NAME Ellsworth Brewer		13b. MOTHER'S MAIDEN NAME Della Roberts	14. NAME OF HUSBAND OR WIFE Mrs. Mary Brewer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 493-42-2976	17. INFORMANT Mrs. Mary Brewer RFD #1 Rosendale, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 3312			INTERVAL BETWEEN ONSET AND DEATH 4-20-59
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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>4-20-59</u> to <u>4-23-59</u> and last saw <sup>him</sup> alive on <u>4-23-59</u> Death occurred at <u>12:05 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Gilbert B. Kelley</u> (Degree or title)		22b. ADDRESS 703 West Highway, Savannah, Mo.	22c. DATE SIGNED 4-21-59
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 4-23-59	23c. NAME OF CEMETERY OR CREMATORY Fillmore Cemetery	23d. LOCATION (City, town, or county) Mo. (State) Fillmore, Missouri
24. FUNERAL DIRECTOR Breit Funeral Home, Savannah		25. DATE RECD. BY LOCAL REG. April 27, 1959	26. REGISTRAR'S SIGNATURE <u>Mr. Clark Goodell</u>

All diseases in Part I must be causally related.  
Dr. Gilbert B. Kelley  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

*James B. Hawkins*

Licensed Embalmer No. *4536*

P. O. Address *Savannah*

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.