

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033340

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 576 Primary Registration District No. 3059 Registrar's No. 337

FILED AUG 26 1963

VS 300
Rev. 4/59

1 0941

2 0945

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u> | | Length of stay in 1b <u>10 days</u> | c. CITY OR TOWN <u>Farmington</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>516 Boyce</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Marvin</u> Middle <u>Paul</u> Last <u>Brewster</u> | | | 4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1963</u> | |
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|-----------------------|----------------------------------|--|------------------------------------|-------------------------------------|---|------------------------------|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/15/10</u> | 9. AGE (last birthday) <u>53</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
|-----------------------|----------------------------------|--|------------------------------------|-------------------------------------|---|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant at Hospital</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Flat River, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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| 13a. FATHER'S NAME <u>Zeno Brewster</u> | 13b. MOTHER'S MAIDEN NAME <u>Frances McGee</u> | 14. NAME OF HUSBAND OR WIFE <u>Elizabeth Brewster</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u> | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Elizabeth Brewster Farmington, Missouri.</u> Address |
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| 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>UREMIA</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> |
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| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> | | 10 yrs |
| DUE TO (c) | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 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.) | |
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| 20c. TIME OF INJURY Hour <u>1:45</u> a.m. p.m. | Month, Day, Year |
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| 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 <u>Farmington</u> | COUNTY | STATE |
|--|--|---|--------|-------|

21. I attended the deceased from 1953 to 8-8-63 and last saw ^{him} alive on 8-8-63
Death occurred at 1:45 PM on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>C. E. Conleton, M.D.</u> | 22b. ADDRESS <u>Farmington Mo</u> | 22c. DATE SIGNED <u>8-10-63</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>8/10/63</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u> | 23d. LOCATION (City, town, or county) <u>Farmington</u> | (State) <u>Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>Miller Funeral Home</u> | ADDRESS <u>Farmington, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>Aug 10, 1963</u> | 26. REGISTRAR'S SIGNATURE <u>C. E. Conleton</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

SEP 10 1963

AUG 29 1963

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 *Paul K. Ruzal*

Licensed Embalmer No. 4120

P. O. Address Farmington 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.