

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038233

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2780

**FILED SEP 25 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)	
a. COUNTY <b>St. Louis</b>		a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Koch</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in lb <b>8 days</b>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1707 Cole</b>	
3. NAME OF DECEASED (Type or print) First <b>Monroe</b> Middle <b>Brewer</b> Last <b>Brewer</b>		4. DATE OF DEATH Month <b>9</b> Day <b>3</b> Year <b>63</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-25-89</b>
10a. USUAL OCCUPATION (Give kind of work done during last year, or even if retired) <b>Red-carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	11. BIRTHPLACE (City and state or country) <b>Alabama</b>
13a. FATHER'S NAME <b>Henderson Brewer</b>		13b. MOTHER'S MAIDEN NAME <b>Jane Swanson Vaughn</b>	14. NAME OF HUSBAND OR WIFE <b>Elizabeth Brewer</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCE (Yes, no, or unknown) (If yes, give war or dates)		17. INFORMANT <b>Robert Koch Hospital, Koch, Mo.</b>	
18. CAUSE OF DEATH (Enter on ly one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis with cerebral Thrombosis and Chronic Brain Syndrome. Generalized Arteriosclerosis</b>			<b>years</b>
DUE TO (b) <b>332x</b>			<b>years</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>Pneumonitis RLL, etiology unknown.</b>			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
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 <b>8-27-63</b>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>8-27-63</b>	20f. CITY, TOWN, OR LOCATION <b>9-3-63</b>
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		COUNTY <b>9-3-63</b> STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <b>11:40 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Reynard Friedman, M.D.</b>		22b. ADDRESS <b>Robert Koch Hospital</b>	22c. DATE SIGNED <b>9-4-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9/9/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR <b>CHARLES J. GATES, JR., 4107 Finney</b>		25. DATE RECD. BY LOCAL REG. <b>9/6/63</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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 Gayton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.