

John P. Brewster M.D. 1940me

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

201 V. S.

DEPARTMENT OF HEALTH OF THE STATE OF NEW JERSEY
BUREAU OF VITAL STATISTICS.

1 PLACE OF DEATH **CERTIFICATE AND RECORD OF DEATH.**

County Burlington 124 State NEW JERSEY Registered No. _____
Township Florence or Village Florence or _____
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ethel Carrell Heast

(a) Residence. No. 19 New South St. _____ Ward _____
Length of residence in city or town where death occurred _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced Married

6a If married, widowed, or divorced
Name of husband or wife of _____

6 DATE OF BIRTH (month, day, and year) July 18, 1896

7 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.
22 2 21

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Smithville
(State or country) New Jersey

10 NAME OF FATHER Abraham H. Carrell

11 BIRTHPLACE OF FATHER (city or town) Smithville
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Anna Grant

13 BIRTHPLACE OF MOTHER (city or town) Crossville
(State or country) New Jersey

14 Informant Howard J. Heast
(Address) Florence, N. J.

15 Filed Oct. 1, 1918 Registrar John H. Slack & Sons

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9 1918

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1918 to Oct. 9 1918
That I last saw her alive on Oct. 9 1918 and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Influenza
(Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?
(Signed) Dr. J. C. Brewster M. D.

19 (Address) Florence, N. J.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION, OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL Oct. 13 1918

20 UNDERTAKER John H. Slack & Sons ADDRESS Florence, N. J.