

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

15128

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. St. Vincent Hosp.)

Registration District No. 399
Primary Registration District No. 1002

File No. 6
Registered No. 1998
St. _____ Ward _____

2. FULL NAME Emma Brown

(a) Residence, No. 340 Cambridge St., _____ Ward. Kansas City Kans.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Ray Brown.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 30, 1898.

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	28	5	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employee) II
(c) Name of employer II

9. BIRTHPLACE (CITY OR TOWN) Mendon
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Chris Timm.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Mary Fischer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Germany.

14. INFORMANT Ray Brown.
(Address) 340 Cambridge

15. May 16 27 M. M. Crowe
FILED _____ 19. 27 Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 16 19 27

17. I HEREBY CERTIFY, That I attended deceased from 5 _____, 1927, to 5-16 _____, 1927 that I last saw her _____ alive on 5-15 _____, 1927, and that death occurred, on the date stated above, at 9:30 A. _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Scarlet fever

(duration) _____ yrs. _____ mos. 6 ds.
CONTRIBUTORY (SECONDARY) Conjunctivitis
Delivered May 8 27 (duration) _____ yrs. _____ mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? St Vincent Hosp.
DID AN OPERATION PRECEDE DEATH? no. DATE OF Delivered 6-8-27

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) [Signature] _____, M. D.
5/16/19 27 (Address) Riverside 12

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brunswick Mo. DATE OF BURIAL 5/18/ 1927
20. UNDERTAKER H. W. Gates ADDRESS K.C.Ks.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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