

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

Do not use this space.

24284

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kaw Primary Registration District No. _____
City Kansas City (No. St. Vincent's Hosp.)

File No. 2071
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Jimmie Lee Brown
(a) Residence No. 4134 Tracy St. 15 Ward _____

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 3-1927

7. AGE YEARS MONTHS DAY If LESS than 1 day, hrs. or min.
- - 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY)

10. NAME OF FATHER Jas. H. Brown

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

12. MAIDEN NAME OF MOTHER Lucy M. Sullivan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) K.C. Mo.
(STATE OR COUNTRY)

14. INFORMANT James H. Brown
(Address) 4134 Tracy

15. FILED 8/6 1927 M. M. Crowe REGISTRAR
act

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 6 19 27

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 to Aug 5 1927 that I last saw him alive on Aug 5 1927, and that death occurred, on the date stated above, at 11:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
160B 161B
160B's Protracted Labor with
difficult delivery
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. Monahan, M. D.

8/6, 1927 (Address) 1400 North Main

*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 Memorial Park DATE OF BURIAL Aug-6-1927

20. UNDERTAKER Mrs. C. L. Foster ADDRESS 916 Brooklyn

N. B.—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.

MISSOURI STATE BOARD OF HEALTH—VITAL RECORDS

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496. written copy

4034 2200.

N.P. 430

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at Washington DC
~~H. H. H. H.~~