WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

16393

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. 2211

Township Kaw — Primary Registration District No. 1002 — Registered No.

City Kansas City (No. Kansas City Gen Hosp St. Ward)

2. FULL NAME Brown L. K.

(a) Residence. No. 9 1/2 W. 5th St., 1 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 16 1883

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	46	7	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook 15
(b) General nature of industry, business, or establishment in which employed (or employer) 15
(c) Name of employer

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9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Texas

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Rewa Clerk
(Address) K.C. Gen. Hosp.

15. FILED 5/26 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-25 1930

17. I HEREBY CERTIFY, That I attended deceased from 5-22, 1930, to 5-25, 1930 that I last saw him alive on 5-25, 1930, and that death occurred, on the date stated above, at 5:55 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Streptococcic cellulitis of arm

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Delirium Tremens

(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) P. E. Williams, M. D.

5/26, 1930 (Address) Gen Hosp K C Mo

*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 Fort Worth Texas — DATE OF BURIAL 5/26 1930

20. UNDERTAKER O. Mast — ADDRESS 1915 East 15