

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

Do not use this space.

39577

1. PLACE OF DEATH

County Jackson
Township Kanawha
City Kansas City, Mo.

Registration District No. 333
Primary Registration District No. St. Lukes Hosp

File No. 51150
Registered No. 51150
St. _____ Ward _____

2. FULL NAME

Joseph S. Brooks
(a) Residence, No. 1326 East 30 St. 4 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Sarah Brooks</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 13 - 1856</u>		
7. AGE	YEARS <u>74</u>	MONTHS <u>4</u>
	DAYS <u>7</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Lawyer</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 20 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1930, to Dec 20, 1930, that I last saw him alive on Dec 19, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Aortic regurgitation
Heart Block
Myocarditis (chronic)
at least (duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
at least (duration) 10 yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Paris Ky
(STATE OR COUNTRY) Ky

10. NAME OF FATHER Leah Brooks

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

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 1326 E 30

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Only the clinical tests
(Signed) G. H. Horie, M. D.
Dec 22, 1930 (Address) 1000 Kialto Bldg

*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.

14. INFORMANT Mrs Sarah Brooks
(Address) 1326 East 30 St

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Paris Ky DATE OF BURIAL Dec 26 - 1930

15. FILED 12/23/30 M. M. Crowe
REGISTRAR Asst

20. UNDERTAKER John W. Wagner ADDRESS Linwood Richmond

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.

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

Dr. G. A. ...
- ...