

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

Do not use this space.

28334

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City, Mo.

Registration District No. 399
Primary Registration District No. 2002
(No. 811 East Armour)

File No. _____
Registered No. 57700
St. 2nd Ward

2. FULL NAME William Brown

(a) Residence. No. 5036 Park St. 11 Ward.

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Anna Belle Brown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4th, 1906

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
25 1 9

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Nevada,
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER W.C. Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Nevada,
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Carrie Withers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lawrence,
(STATE OR COUNTRY) Kansas

14. INFORMANT Mrs. Anna Belle Brown
(Address) 5036 Park, K.C.Mo.

15. FILED 8/14, 1931 M.M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-13 1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Suicide, carbolic acid a poison

CONTRIBUTORY (SECONDARY) 163
(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? autopsy
(Signed) Stanley M. Hall, M. D.
8/14, 1931 (Address) Deputy Coroner

*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 Nevada, Mo. DATE OF BURIAL 8-16-31 1931

20. UNDERTAKER R.V. Lindsey & Sons, Inc. ADDRESS K.C.Mo.

WRITE PERMANENT, 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.

