

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

Do not use this space.

1292

1. PLACE OF DEATH

County Jackson Registration District No. 322
Township How Primary Registration District No. 100
City Kansas City (No. Gen. Hosp # 2) St. _____ Ward _____

File No. _____
Registered No. 330
St. _____ Ward _____

2. FULL NAME

Cornelia Brown
(a) Residence. No. 2445 Ways St., Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred 26 yrs. 7 mos. 15 ds. 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 colored 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) 11-30-1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
20 1 27

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work laborer 2371
(b) General nature of industry, business, or establishment in which employed (or employer) Unemployed
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shawnee 2
Kans

10. NAME OF FATHER Pass Brown

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

12. MAIDEN NAME OF MOTHER Fannie Cannon

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

14. INFORMANT Record Clerk
(Address) Gen Hosp # 2

15. FILED Jan 28 1932 M. M. Carome
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-27-1932

17. I HEREBY CERTIFY, That I attended deceased from 1-12-1932 to 1-27-1932 that I last saw him alive on 1-27-1932, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
cellulitis of right
520 arm
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Toxemia
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. (1)

DID AN OPERATION PRECEDE DEATH. no DATE OF _____
WAS THERE AN AUTOPSY no

WHAT TEST CONFIRMED DIAGNOSIS culture of lab
(Signed) W. M. Miller M. D.
(Address) Gen Hosp # 2

*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 Shawnee, Kansas DATE OF BURIAL 1/30 1932

20. UNDERTAKER Hatkins Prothdt Co ADDRESS 1729 Lydia

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.

