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.

DEC 19 1938

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

39388
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 3 Registration District No. 396
(b) Township Ft. Osage 2 Primary Registration District No. 5552 Registered No.
(c) City Buckner US Hiway No. 24. (d) Street No. at 2nd Bridge west of town. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 650 Della Fern Brown (This address one year)
(a) Residence, No. 8½ South 7th. Street St. Kansas City Kansas
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 2. 1921.

7. AGE YEARS 16 MONTHS 11 DAYS ~~25~~ If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Waitress
9. Industry or business in which work was done, as saw mill, bank, etc. XX
10. Date deceased last worked at this occupation (month and year) XX
11. Total time (years) spent in this occupation XX

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chillicothe Mo.

FATHER
13. NAME Daniel O. Brown.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gallatin Mo.

MOTHER
15. MAIDEN NAME Sarah Alice Mason
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gallatin Mo.

17. INFORMANT (ADDRESS) Sarah Alice Brown 8½ So. 7th St. KC Ks.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hiland Park KC Kansas DATE 10/11/38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) V.M. Reppert 2321 Buckner Mo.

20. FILED Oct. 8, 1938 John W Rotatson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 8. 1938, 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 1 AM. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Both shoulders broken	
Both upper arms broken	
Both thighs broken- crushed	
Rt Jaw broken- Rt hip broken	
Left Elbow broken	
Ribs left side broken	

Other contributory causes of importance:
Hemorrhage both ears

Name of operation None Date of
What test confirmed diagnosis? Observation Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 10-8, 1938
Where did injury occur? Highway #24 (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Highway #24 1/4 mi. W Buckner No
Manner of injury Car struck Bridge
Nature of injury Broken leg-shoulder Skull Fr. No

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) [signature], M. D.
35 (Address) Deg Coroner

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

V.M.Reppert, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed V. M. Reppert

Licensed Embalmer No. 2321

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.