

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.

370 OCT 18 1939

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

31388  
Do not use this space.

1. PLACE OF DEATH

(a) County JACKSON Registration District No. 395  
(b) Township KAW Primary Registration District No. 1002  
(c) City KANSAS CITY (d) Street No. ST. JOSEPH'S HOSPITAL Registered No. 3488  
(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

1050 MRS. MYRTLE EATON BRUUN  
(a) Residence, No. PARK LANE HOTEL BLDG # 206 St.   
4600 MILL CREEK PARKWAY (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) DIVORCED  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF CHARLES A. BRUUN  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JULY 18 1874  
7. AGE YEARS 65 MONTHS 1 DAYS 15 If LESS than 1 day, hrs. or min.

OCCUPATION

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MUSCATINE IOWA

FATHER 13. NAME JAMES A. EATON

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) INDIANA

MOTHER 15. MAIDEN NAME UNKNOWN

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

17. INFORMANT (NAME) (ADDRESS) MR. JAMES A. BRUUN 5987 BASEO

18. BURIAL, CREMATION, OR REMOVAL PLACE FOREST HILL DATE SEPTEMBER 25 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) D. W. NEWCOMER'S SONS 1401 BRUSH CREEK BLYD.

20. FILED 1939 M. M. Grove Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) SEPTEMBER 2 1939

22. I HEREBY CERTIFY, That I attended deceased from January 31 1936 to 9-2-39, 1939  
I last saw her alive on 9-2-39, 1939 Death is said to have occurred on the date stated above, at 6:45 P.M.  
The principal cause of death and related causes of importance were as follows:

Cerebral Occlusion 1934  
Other contributory causes of importance: Cerebral Arterio-sclerosis 1932  
Date of onset

Name of operation Date of  
What test confirmed diagnosis Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? Date of injury 19  
Where did injury occur? (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury  
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify None  
(Signed) D. W. Waldron M. D.  
1401 Brush Creek Blyd.

**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, \_\_\_\_\_, or by \_\_\_\_\_

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

Signed *H. C. Newcomb Jr.*

Licensed Embalmer No. 40430

P. O. Address *H. C. Newcomb*

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

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

*At Jackson, Mississippi*