

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

5483

Registration District No.

399

Primary Registration District No.

1002

Registrar's No.

708

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3229 Wabash Ave. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 23 Yrs.
years, months or days

3. (a) PRINT FULL NAME James LeRoy Brown

3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Laura Brown 6. (c) Age of husband or wife if alive 59 years
 7. Birth date of deceased Febr. 15 1873
(Month) (Day) (Year)

8. AGE: Years 67 Months 0 Days 01 If less than one day _____ hr. _____ min.

9. Birthplace Westmorland Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Formally book store

MOTHER FATHER { 12. Name Thos. H. Brown
 13. Birthplace Clermont Ohio
(City, town, or county) (State or foreign country)
 14. Maiden name Louisa Hill
 15. Birthplace Clermont Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Laura Brown
 (b) Address 3229 Wabash

17. (a) Burial (b) Date thereof Jan 19 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah
 18. (a) Signature of funeral director Eylar Funeral Home
 (b) Address 1800 Linwood Blvd. K.C. Mo.

19. (a) 2-17-40 (b) m.m. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town 3229 Wabash Ave. K.C. Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. 3229 Wabash Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16
 year 1940 hour 4 minute _____ A. M.

21. I hereby certify that I attended the deceased from April, 1937, to Feb. 16, 1940
 that I last saw him alive on Feb. 15, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis Duration 3 1/2
 Due to 12/01

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature R.P. Miller (M. D. or other) _____
 Address 1502-2-314 Date signed 2/16/40

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.....

Chaswick

Licensed Embalmer No. *2644*

P. O. Address *1800 Inwood*

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.