

## STANDARD CERTIFICATE OF DEATH

State File No. 5830

5830

Registration District No. 50Primary Registration District No. 507.3004Registrar's No. 17

## 1. PLACE OF DEATH:

(a) County Bates  
 (b) City or town Butler  
 (c) Name of hospital or institution: Home 409 E Smith St.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 (Specify whether  
 In this community 5 years  
 years, months or days)

3. (a) PRINT FULL NAME Margaret Brown3. (b) If veteran, name war. V 3. (c) Social Security No. V4. Sex Female 5. Color or race B 6. (a) Single, widowed, married, divorced Widow6. (b) Name of husband or wife Went Knowl 6. (c) Age of husband or wife if alive ✓ years7. Birth date of deceased March 11 1857  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
82 10 27 hr. min.9. Birthplace Cass Co. Mo. (City, town, or county) (State or foreign country)10. Usual occupation House work

11. Industry or business

12. Name George Brown13. Birthplace Went Knowl (City, town, or county) (State or foreign country)14. Maiden name Went Knowl15. Birthplace Went Knowl (City, town, or county) (State or foreign country)16. (a) Informant's own signature Doris D. Bell(b) Address 228 Bouyer Lane17. (a) Harrisonville Mo (b) Date received Feb 2 (Month) (Day) (Year)(c) Place: burial or cremation Went Knowl18. (a) Signature of funeral director RUBEN FOREMS(b) Address HARRISONVILLE, MO.19. (a) Feb 2 (Date received local registrar) (b) W. M. C. C. C. (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bates  
 (c) City or town Butler  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 409 E Smith St  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 7 years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1 year 1940 hour 7 minute P M.21. I hereby certify that I attended the deceased from Oct 31, 1939, to Feb 1, 1940  
that I last saw her alive on Feb 1, 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral Stomach

Due to \_\_\_\_\_

Due to H/O

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 W. M. C. C. C. (M. D. or other) 1Address Butler, Mo Date signed 2-1-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

FILED MAR 16 1940

RECEIVED  
District Health Officer No. 7,  
District file Number 3-40-466  
Date Filed 3-14-40

**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 Ernest Pannenburg  
Licensed Embalmer No. 3368  
P. O. Address Harrisonville Mo

**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.**