

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 400

Primary Registration District No. 55534 4735 Registrar's No. 26

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Lee's Summit
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 55 yrs (years, months or days)

3. (a) PRINT FULL NAME SALLY ANN BROWNING

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife E. J. Browning 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 2 1855
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Pendleton Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Carson Waudelohr

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Ellenor Mullins

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elizabeth Browning

(b) Address Lee's Summit Mo

17. (a) Burial (b) Date thereof Feb 20
(Burial, cremation, or removal) (Month), (Day) (Year)

(c) Place: burial or cremation Lee's Summit

18. (a) Signature of funeral director F. M. Schick & Son

(b) Address Lee's Summit Mo

19. (a) 2-19-40 (b) Sam S. Barnes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Lee's Summit
(If outside city or town limits, write "RURAL")

(d) Street No. 202 West 3rd St
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18 year 1940 hour 12:4 minute 45 PM

21. I hereby certify that I attended the deceased from 2-7, 1940 to 2-18, 1940 that I last saw her alive on 2-18-, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory pneumonia Duration 1 da
chronic myocarditis ?

Due to _____

Due to _____

Other conditions fracture left hip 11 da
(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 [Signature] (M. D. or other) 1940

Address Lee's Summit Mo Date signed 2/19/40

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.

REV. 5-17-30 1 X19511

1994/13

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..... *F. M. Schick*.....

Licensed Embalmer No..... *1856*.....

P. O. Address..... *Lee's Summit 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **6878**

Registration District No. **400**

Primary Registration District No. **4235-**

Registrar's No. **26**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Lee Summit**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Sally Ann Browning**

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ h. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Feb** day **18** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction**
Chronic
Myocarditis

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **Fracture left hip**
Major findings:
Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) **Accident**

(b) Date of occurrence **2-7-40**

(c) Where did injury occur? **Lee Summit, Jackson Mo.** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **In home**
While at work _____ (Specify type of place) (e) Means of injury **fall**

23. Signature **J. F. Knight** (M. D. or other)

Address **Lee Summit** Date **2/18/40**

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

S-6878