DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D APR 12 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9636

Primary Registration District No. 1002

Registrar's No. 1070

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.

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: K.C. General Hospital No. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days (Specify whether years, months or days)

In this community 28 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City (If outside city or town limits, write "RURAL")

(d) Street No.: 3222 Charlotte (If rural, give location)

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

3. (a) PRINT FULL NAME: ADELAIDE BRAY 600

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Fe

5. Color or race: Wh

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: John Bray

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: Nov (Month) 10 (Day) 1876 (Year)

8. AGE: Years 63 Months 3 Days 27 If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Hiram Mc Daniel
13. Birthplace: Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Ann Johnson
15. Birthplace: Missouri (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Charley Bray

(b) Address: 3222 Charlotte

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 3-9-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenlawn

18. (a) Signature of funeral director: Quirk & Tobin Co

(b) Address: 20 W. Linwood

19. (a) Mch 8, 1940 (Date received local registrar) (b) M. M. Browne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7th year 1940 hour 2 minute 15 A.M. M.

21. I hereby certify that I attended the deceased from 2-21-40, 19__, to 3-7-40, 19__; that I last saw her alive on 3-7-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Adenocarcinoma of sigmoid with rupture and peritonitis — Duration: 4 hr

Due to: ____

Due to: ____

Other conditions: Pulmonary congestion (Include pregnancy within 3 months of death)

Major findings:
Of operations: ____
Of autopsy: See above

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? (Specify type of place)

While at work? ____ (e) Means of injury: ____

23. Supt. K.C. Gen. Hospital, K.C. Mo. (M. D. or other)

Address: ____ Date signed: ____

(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, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.