DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9637

Registration District No. 399 12 1940

Primary Registration District No. 1002

Registrar's No. 1071

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: General Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-1-40-3-5-40 (Specify whether

In this community 1 Year years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 5622 E. 34th St. (If rural, give location)

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

3. (a) PRINT FULL NAME Aquille Brown 650

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife Josie Brown

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

7. Birth date of deceased May (Month) 26 (Day) 1880 (Year)

8. AGE: Years 59 Months 9 Days 9 If less than one day ..... hr. ..... min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Glen Brown
13. Birthplace ..... (City, town, or county) Ga (State or foreign country)

MOTHER
14. Maiden name Sarah
15. Birthplace ..... (City, town, or county) Ga (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/40 (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln

18. (a) Signature of funeral director Watkins Bros

(b) Address 1729 Lydia

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 5 year 40 hour 4 minute 20 P. M.

21. I hereby certify that I attended the deceased from 2-1- , 1940 to 3-5- , 1940 that I last saw him alive on 3-5- , 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Far Advanced Pulmonary Tuberculosis.	
Due to 22	
Due to	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Gen. Hosp. #2 Date signed 3-6-40

(Licensed Embalmer's Statement on Reverse Side)

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.

I X19511

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.....Isaac Jerome Menlove

Licensed Embalmer No.....3994

P. O. Address.....1206 23rd St.

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.