

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

399

 MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 9752

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1185

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (c) Name of hospital or institution: 3007 Lister Avenue
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 12 Years.
 years, months or days)

3. (a) PRINT FULL NAME Mrs. Stella Amelia BRATON3. (b) If veteran, name war. No. 3. (c) Social Security No. No.4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife William Braton 6. (c) Age of husband or wife if alive 79 years7. Birth date of deceased May 14, 1862
(Month) (Day) (Year)8. AGE: Years 77 Months 10-- Days _____ If less than one day hr. _____ min. _____9. Birthplace Montrose, Iowa
(City, town, or county) (State or foreign country)10. Usual occupation At Home

11. Industry or business

 MOTHER FATHER
 { 12. Name Adolphus Johnson
 { 13. Birthplace Iowa
 { 14. Maiden name Helissa Menier
 { 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Virgil E. Dayton
(b) Address 2801 Jackson17. (a) Burial (b) Date thereof Mar. 16 '40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cemetery18. (a) Signature of funeral director Mollody - McGillroy
(b) Address K. C. Mo.19. (a) 3-17-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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. 3007 Lister Avenue
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 14
year 1940 hour _____ minute 5 A M.21. I hereby certify that I attended the deceased from Feb 10 1940 to Mar 14 1940
that I last saw her alive on Mar - 13 1940
and that death occurred on the date and hour stated above.
 Immediate cause of death _____
Interstitial Nephritis
 Due to _____
Chronic
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 Due to _____
Other conditions Uremic Coma 5-dg
(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:

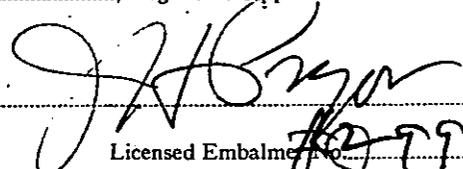
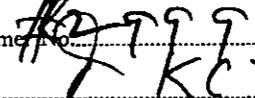
(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 _____ (Specify type of place)
 While at work? _____ (e) Means of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

23. Signature F. H. Evans (M. D. or other)
Address 520 Oggle Date signed 3/16/40

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 .....
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.