11-10-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9867

Registration District No. 399 APR 13 1940

Primary Registration District No. 1002

Registrar's No. 1301

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: Trinity Lutheran Hospital, (If not in hospital or institution, write street number or location)

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

In this community: Unknown,

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.: 3628 Holmes St., (If rural, give location)

(e) If foreign born, how long in U. S. A.? no. years.

3. (a) PRINT FULL NAME: J. George Brinkman, 652

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

3. (c) Social Security No.: no.

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: L. Pauline W. Brinkman,

6. (c) Age of husband or wife if alive: 70 years

7. Birth date of deceased: June (Month) 21 (Day) 1868 (Year)

8. AGE: Years 71 Months 9 Days 4 If less than one day hr. min.

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

10. Usual occupation: Retired

11. Industry or business: x

FATHER 12. Name: J. V. Brinkman,

FATHER 13. Birthplace: Ohio, (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Lebold,

MOTHER 15. Birthplace: Ohio, (City, town, or county) (State or foreign country)

16. (a) Informant: J. V. Brinkman,

(b) Address: 3325 Gillham Kansas City, Mo.

17. (a) Burial, (Burial, cremation, or removal) (b) Date thereof: 3-27-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Forest Hill Cemetery

18. (a) Signature of funeral director: Stine & McClure,

(b) Address: 3235 Gillham Plaza, Kansas City, Mo.

19. (a) Mch 25, 1940 (Date received local registrar) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25th, year 1940 hour 3:00 minute A. M.

21. I hereby certify that I attended the deceased from 1-2- 1939 to 3/25 1940 that I last saw him alive on 3/25 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: 1-Intestinal destruction	
Due to: 2-Vascular nephritis advanced	
3-Chronic hepatitis secondary to	
Due to: Chronic cholelithiasis	
Other conditions (Include pregnancy within 3 months of death): 1216	

Major findings: Of operations: Gall stones

Of autopsy: 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. Signature: Wm H Temple (M. D. or other)

Address: Temple Hospital 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 J. B. Yates

Licensed Embalmer No. 3992

P. O. Address K C Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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STANDARD CERTIFICATE OF DEATH

State File No. 9867

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1301

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C.
(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 years, months or days)

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.

3. (a) PRINT FULL NAME J. n. m. George Brinkman

3. (b) If veteran name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

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 71 Months 9 Days 4 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 3/25/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 25 year 1940 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
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 Wm. K. Trump (M. D. or other)
Address Trinity Hosp. Date signed

SUPPLEMENTARY

S-9867 1940