

Registration District No. 399

Primary Registration District No. 1102

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(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 1 and 14 days  
(Specify whether  
In this community 40 years  
years, months or days)

3. (a) PRINT FULL NAME DAVID BRUER  
3. (b) If veteran, name war No  
3. (c) Social Security No. None

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Elizabeth Bruier  
6. (c) Age of husband or wife if alive years 31 1859  
7. Birth date of deceased Jan 31 1859  
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 16 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business Tailor

MOTHER FATHER  
12. Name Adam Bruier  
13. Birthplace Russia  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Herbel  
15. Birthplace Russia  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Alex Bruier  
(b) Address 2703 Holly

17. (a) Bureau (b) Date thereof May 20 - 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director G. W. Wagner  
(b) Address K.C. Gen. Hospital

19. (a) May 17, 1940 (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. 1124 W. 26th St. Terrace  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 17th  
year 1940 hour 1 minute 25 A. M.  
21. I hereby certify that I attended the deceased from 3-23-40, 19\_\_\_\_, to 5-17-40, 19\_\_\_\_;  
that I last saw h. im alive on 5-17-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pyelonephritis; Gangrenous cystitis  
Due to \_\_\_\_\_  
Due to 59  
Other conditions Diabetes  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy None  
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 G. F. De Maria M.D. (M. D. or other) \_\_\_\_\_  
Address Supt. K.C. Gen. Hospital, K.C. Mo. Date signed \_\_\_\_\_

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.

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**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..... *Cecil R. Matthes* .....

Licensed Embalmer No. *K.E. No* .....

P. O. Address *3807* .....

**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.**