

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20910**
Registrar's No. **2527**

Registration District No. **399** Primary Registration District No. **1002**

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **19 days** (Specify whether
In this community **23 years**
years, months or days)

3. (a) PRINT FULL NAME **ALONZO BRIAN** **650**
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 **wid.**
6. (b) Name of husband or wife **---** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **Oct. 6th 1858** (Month) (Day) (Year)

8. AGE: Years **81** Months **8** Days **11** If less than one day **hr. min.**

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

10. Usual occupation **None**

11. Industry or business

MOTHER FATHER
12. Name **James Brian**
13. Birthplace **Ky.** (City, town, or county) (State or foreign country)
14. Maiden name **Julia Stafford**
15. Birthplace **Ky.** (City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**

(b) Address **K.C. General Hospital**

17. (a) **Burial** (b) Date thereof **6-19-40** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Municipal Cem. Leeds, Mo.**

18. (a) Signature of funeral director **W.A. Lehmeyer**
(b) Address **City mortician**

19. (a) **June 21, 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. **2701 Linwood** (If rural, give location)
(e) If foreign born, how long in U. S. A.? **---** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **18th** year **1940** hour **5:30 A.M.** minute **---** M.

21. I hereby certify that I attended the deceased from **May 29th 1940** 19 **---** to **June 17th, 1940** 19 **---**; that I last saw him alive on **June 17th, 1940** 19 **---**; and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive heart disease with de-compensation**

Due to **95 B**

Other conditions **Arteriosclerotic gangrene left leg** (Include pregnancy within 3 months of death)

Major findings: Of operations **---**
Of autopsy **None**

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 **P. F. DeMunn MD** (M. D. or other)
Address **Supt. K.C. Gen. Hospital, K.C. Mo.** Date signed **---**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Wm A. Lehman*
.....
Licensed Embalmer No. *3089*

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.