S. No. 2
—11-10-39
. 5-17-39
I X21492

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

FILED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24261

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2871

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 15 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 2617 East 29th Street
(If rural, give location)

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

3. (a) PRINT FULL NAME Margaret E. BRAINERD. 656

3. (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 Widowed

6. (b) Name of husband or wife Thomas E. Brainerd.

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

7. Birth date of deceased August 14th, 1868
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
71	11	3	hr. min.

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

10. Usual occupation At Home

11. Industry or business

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

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

16. (a) Informant Mrs. C. H. Allison
(b) Address 2617 East 29th Street.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/40
(Month) (Day) (Year)
(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Mellody-McGilley
(b) Address K. C. Mo.

19. (a) July 18, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 17-40
year hour minute 1:45 P M.

21. I hereby certify that I attended the deceased from 7-13-40, 19, to 7-17-40, 19;
that I last saw her alive on 7-17-40, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Encephalomalacia

Due to Cerebral Embolism 92 d

Due to Rheumatic Mitral Stenosis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Above

Duration

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 [signature] 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 .....

Licensed Embalmer No. 2999

P. O. Address ..... K C M

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.