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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27616**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3250**

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 No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days** (Specify whether
In this community **36 yrs**
years, months or days)

3. (a) PRINT FULL NAME **Grant Brennan** **655**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **496-01 5053**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Raune Brennan** 6. (c) Age of husband or wife if alive **62** years

7. Birth date of deceased **Nov 16 1892**
(Month) (Day) (Year)

8. AGE: Years **67** Months **7** Days **29** If less than one day hr. min.

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

10. Usual occupation **W.P.A.**

11. Industry or business

MOTHER FATHER { 12. Name **Catrick Brennan**

18. Birthplace **Ireland** 5
(City, town, or county) (State or foreign country)

14. Maiden name **Jane Campbell**

15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Raune Brennan**

(b) Address **1317 Bales**

17. (a) **Burial** (b) Date thereof **Aug - 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt Washington**

18. (a) Signature of funeral director **Mrs C. L. Johnston**

(b) Address **918 Brooklyn**

19. (a) **Aug. 17, 1940** (b) **M. M. Erseve**
(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 limit, write "RURAL")
(d) Street No. **1217 Bales** (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **15th**
year **1940** hour **2** minute **23 P** M.

21. I hereby certify that I attended the deceased from **8-13-40**, 19____, to **8-15-40**, 19____;
that I last saw him alive on **8-15-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute coronary occlusion with acute infarction**

Due to **948**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **See above**

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 **Dr. R. P. Shaw** (M. D. or other) _____
Address **Med. Dir. K.C. Gen. Hosp., 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. 5700 0

Signed *Denzil C. Browning*

Licensed Embalmer No. *2724*

P. O. Address *A. C. Mo*

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.