FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31164

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3727

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

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: General Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9-10-40 to 9-21-40 (Specify whether years, months or days)

In this community 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 1515 E. 22nd Street (If rural, give location)

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

3. (a) PRINT FULL NAME Verline Foreman Brasher

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Unknown Bernadine Brasher

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

7. Birth date of deceased 5 (Month) 30 (Day) 1922 (Year)

8. AGE: Years 18 Months 3 Days 22 If less than one day ..... hr. ..... min.

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

10. Usual occupation none

11. Industry or business

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

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

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9/25/40 (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Watkins Bros

(b) Address 1729 Lydia

19. (a) 9-25-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 21 year 40 hour 2 minute 30 A. M.

21. I hereby certify that I attended the deceased from 9-10- , 1940 to 9-21-40 , 19 ; that I last saw her alive on 9-21-40 , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis.	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 23	
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 [signature] (M. D. or other)

Address Gen. Hosp. #2 Date signed 9-21-40

(Licensed Embalmer's Statement on Reverse Side)

APR 20 1949

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 Isaac Jerome Manlow

Licensed Embalmer No. 3994

P. O. Address 1120 E. 23rd St.

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

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