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-39  
23159

FILED OCT 11 1940  
STANDARD CERTIFICATE OF DEATH

State File No. **31170**  
Registrar's No. **3733**

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:  
2519 Walrond Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution -----  
(Specify whether  
In this community 29 Years  
years, months or days)

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. 6220 Wabash Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? ----- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 24 day Sept  
year 1940 hour 7 minute 30 P. M.  
21. I hereby certify that I attended the deceased from March 21  
1940 to Sept 24 1940;  
that I last saw her alive on Sept 24 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
hypostatic Pneumonia 2 days  
Due to myocardial Degeneration 2 mos.  
Due to malignancy of Bilary Passages 6 mo.  
Other conditions  
(Include pregnancy within 3 months of death) 46

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

Major findings:  
Of operations  
Of autopsy

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 John M. Lawrence (M. D. or other) M.D.  
Address 3322 1/2 E. 27th St Date signed 9/25/40

3. (a) PRINT FULL NAME Mrs. Henrietta Brotherton

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Mr. Robert Brotherton 6. (c) Age of husband or wife if alive ----- years  
7. Birth date of deceased June 9 1854  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 3 15 hr. min.

9. Birthplace Herkimer County New York  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business -----

12. Name Guy C. Smith

13. Birthplace New York  
(City, town, or county) (State or foreign country)

14. Maiden name Emily Woodrick

15. Birthplace New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ed A Higgins

(b) Address 2519 Walrond Avenue

17. (a) Burial (b) Date thereof Sept. 26, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cen.

18. (a) Signature of funeral director W. H. Newcomb

(b) Address 1401 Brush Creek Blvd.  
19. (a) 9-26-40 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

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

*Boydman  
1116 Prof*

*1-6  
M. H. Boydman & Sons*

**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 *George M. Collier*

Licensed Embalmer No. *3839*

P. O. Address *H. C. Mo*

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

**If this body is not embalmed, fact should be so stated above.**