

NOV 12 1949  
Registration District No. 1002

Primary Registration District No.

1002

Registrar's No.

4135

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 12-15-39-10-25-40  
(Specify whether years, months or days) 8 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. 1808 1/2 Forest Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Joseph Brown  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_  
4. Sex Male 5. Color Colored 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 2 27 1892  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 10 day 25  
year 40 hour 5 minute P. M.  
21. I hereby certify that I attended the deceased from 12-15- 1939 to 10-25- 1940  
that I last saw him alive on 10-25- 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Penis (Penisectomy)  
Due to Decubitus 51  
Due to Ulceration and Toxicity  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

8. AGE: Years Months Days If less than one day  
48 7 28 hr. \_\_\_\_\_ min.  
9. Birthplace Texas  
(City, town, or county) (State or foreign country)  
10. Usual occupation Not employed  
11. Industry or business \_\_\_\_\_  
12. Name James Brown  
13. Birthplace Texas  
(City, town, or county) (State or foreign country)  
14. Maiden name Eliza  
15. Birthplace Texas  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk  
(b) Address Gen. Hosp. #2  
17. (a) \_\_\_\_\_ (b) Date thereof 10-29-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Blue Ridge Lawn  
18. (a) Signature of funeral director Brady  
(b) Address 1119 E 15th St  
19. (a) 10-29-40 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_  
28. Signature J. O. Thomas (M. D. or other) \_\_\_\_\_  
Address Gen. Hosp. #2 Date signed 10-25-40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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 *L. J. Harris*

Licensed Embalmer No. 3388

P. O. Address K. 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.**