

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

WIS 3 10 AM 399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1002

State File No. 41237
4630

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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 11-29-40-12-4-40
(Specify whether years, months or days)
In this community 25 years

3. (a) PRINT FULL NAME Bernard Brooks

3. (b) If veteran, name war NO 3. (c) Social Security No. 500-03-1787

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

6. (b) Name of husband or wife Blanche Brooks 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased 9 (Month) 23 (Day) 1892 (Year)

8. AGE: Years 49 Months 2 Days 11 If less than one day hr. _____ min. _____

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

10. Usual occupation Unemployed.

11. Industry or business _____

12. Name Edward Brooks.

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

14. Maiden name Mary Perry

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

16. (a) Informant's own signature Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 12-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland, K.C. Mo

18. (a) Signature of funeral director W. M. Crowe

(b) Address _____

19. (a) 12-5-40 (b) W. M. Crowe
(Date received local registrar) (Registrar's signature)

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. 2519 Park.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 4
year 40 hour 8 minute 55 A.M.

21. I hereby certify that I attended the deceased from 11-29- 1940, to 12-4- 1940
that I last saw him alive on 12-4- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Far Advanced Pulmonary Tuberculosis. Duration _____

Due to Pleurisy and Effusion

Due to Corelation 23

Other conditions _____
(Include pregnancy within 3 months of death)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. O. Brown (M. D. or other) _____

Address Gen. Hosp #2 Date signed 12-4-40

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically

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

Edw J Evans

Licensed Embalmer No.

3876

P. O. Address

1819 E 15th St KC 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.