S. No. 2
—11-10-39
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I X21492

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

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1056

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 16

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
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether years, months or days)

In this community 8 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 110

(c) City or town Kansas City 3 0
(If outside city or town limits write "RURAL")

(d) Street No. 1631 Jefferson
(If rural, give location)

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

3. (a) PRINT FULL NAME CHARLES BRAND

3. (b) If veteran, name war Spanish American

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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 April (Month) 12 (Day) 1868 (Year)

8. AGE: Years 73 Months 8 Days 19 If less than one day ____ hr. ____ min.

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

10. Usual occupation Physician

11. Industry or business

FATHER
12. Name Peter Brand
13. Birthplace Germany (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Germany (City, town, or county) 4 (State or foreign country)

16. (a) Informant Mrs. Mollie Owens
(b) Address 1631 Jefferson St. K. C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-41 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Weilert Funeral Home
(b) Address 2332 Monitor Place; K. C. Mo.

19. (a) Jan 3, 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 1st year 1941 hour 12 minute 45 P. M.

21. I hereby certify that I attended the deceased from 12-26-40, 19__, to 1-1-41, 19__; that I last saw him alive on 1-1-41, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death LOBAR PNEUMONIA — (108)

Due to

Due to 108

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy
None

Duration

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 0

23. Signature Harry R. Shaw (M. D. or other)
Med. Dir. K.C. Gen. Hospital, K. C. Mo.
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Blaine E. Weilert

Licensed Embalmer No. 4075

P. O. Address 2332 Monitor Place

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.