

DEC 22 1941 399

Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH: **Jackson,**
(a) County _____
(b) City or town **Kansas City,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Menorah Hospital,**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day,**
In this community **as above,** (Specify whether years, months or days)

3. (a) PRINT FULLNAME **Clarence ² Brown,**
(b) If veteran, name war **No** (c) Social Security No. **No**

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

6. (b) Name of husband or wife **Mrs. Perita Brown,** 6. (c) Age of husband or wife if alive **28** years

7. Birth date of deceased **Jan 16 1870**
(Month) (Day) (Year)

8. AGE: **61** Years **71** Months **9** Days **24** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired.**

MOTHER FATHER
11. Industry or business _____
12. Name **Zelara Brown**
13. Birthplace **New York**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary O. Armstrong**
15. Birthplace **N. Y.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Thornton Sanborn,**
(b) Address **The Walnuts, Kansas City, Mo.**

17. (a) **Burial** (b) Date thereof **Jan 13 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Forest Hill Cemetery**

18. (a) Signature of funeral director **Stine & McClure,**
(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **11-13-41** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **4800**
(a) State **Missouri** (b) County _____
(c) City or town **Hickman Mills,**
(If outside city or town limits, write "RURAL")
Clifton Farms, /
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **10th**
1941 year _____ hour _____ minute _____ F. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral thrombosis (Basilar artery)** Duration **1 day.**

Due to **arterio-sclerosis** ?

Due to **83B**

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

Major findings: Of operations _____
Of autopsy **see above.**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury **0**

23. Signature **F. H. Charles** (M. D. or other) _____
Address **1405 Bryant Bldg** Date signed **1/13/41**

Drs. Sophian and Scharles,

Anyant

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 *E. M. Plank*

Licensed Embalmer No. *1848*

P. O. Address *T. 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, fact should be so stated above.

STATE BOARD OF HEALTH

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **4214**

1. PLACE OF DEATH:

(a) County
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME **Clarence K. Brown**

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex 5. Color or race 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **71** Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address **12/30/41**
19. (a) (b) **M. M. Brown** (Registrar's signature)

(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV** day **10** year **1941** hour minute M.

21. I hereby certify that I attended the deceased from **Nov 9, 1941** to **Nov 10, 1941** and that death occurred on the date and hour stated above.
Immediate cause of death: **Cerebral thrombosis (basilar artery)**
Due to **arteriosclerosis**

Due to
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
Signature **J. H. Schuler** (M. D. or other)
Address **1406 Bryant Bldg** Date signed

Duration

2 1/2 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

MOTHER FATHER

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

State of Mo
County of Jackson } SS.

State File No. _____
Local Registrar's No. 4214

AFFIDAVIT FOR CORRECTION OF A RECORD

On this 16 day of March, 1942 before me appears
Fred B. Mertzheimer, who, upon his oath, states that the original record of ~~birth~~ death
for Clarence Z. Brown died 11-10, 1941, in the State of
Missouri, and which was filed at K.C. on 11-13, 1941, should be corrected as follows:

Item No. 3 should read Clarence Z. Brown
Instead of _____

Item No. _____ should read _____
Instead of _____

Item No. _____ should read _____
Instead of _____

Item No. _____ should read _____
Instead of _____

Item No. _____ should read _____
Instead of _____

Item No. _____ should read _____
Instead of _____

Item No. _____ should read _____
Instead of _____

Item No. _____ should read _____
Instead of _____

Item No. _____ should read _____
Instead of _____

Item No. _____ should read _____
Instead of _____

Item No. _____ should read _____
Instead of _____

Item No. _____ should read _____
Instead of _____

The above is true to the best of my knowledge, information and belief.

(SEAL)

Attorney for Estate
Fred B. Mertzheimer
Relationship.
1009 Lucas Beach Bldg
Present Address.

Subscribed and sworn to before me this 16 day of March, 1942

My Commission Expires Jan. 15, 1946
Rosa A. Marks Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.