

Registration District No. **400**

Primary Registration District No. **5553B**

Registrar's No. **5**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Prater Township**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Jackson County Home for the Aged
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **21 days**
In this community **13 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Jackson 48**
(c) City or town **Kansas City 8**
(If outside city or town limits, write "RURAL")
(d) Street No. **308 Earlfield Ave 4**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **Vera Brand**

3. (b) If veteran, name war **no**
3. (c) Social Security No. **487-16-2515**

4. Sex **Female** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **married 3**
6. (b) Name of husband or wife **unknown**
6. (c) Age of husband or wife if alive **14** years
7. Birth date of deceased **Jan 14 - 1889**
(Month) (Day) (Year)

8. AGE: Years **52** Months **11** Days **22**
If less than one day hr. min.

9. Birthplace **Jacksonville New York**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife + Musician**

11. Industry or business **Home**

MOTHER FATHER { 12. Name **unknown 9**
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name **unknown 9**
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant **Reeds, Jackson County Home**
(b) Address **Little Blue, Mo**

17. (a) **Burial** (b) Date thereof **1-10-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Leis Summit**

18. (a) Signature of funeral director **H.B. Langford**
(b) Address **Leis Summit Mo**

19. (a) **1-10-42** (b) **Sara G. Barnes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **6**
year **1942** hour **8** minute **45** a.m.
21. I hereby certify that I attended the deceased from **12/17-41**
to 1/6, 19**42**, to 19**42**
that I last saw him alive on **1/6**, 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death **neutral respiration**
Duration

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **92 lb**
Of autopsy

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.....

23. Signature **J.W. Greene** (M. D. or other)
Address **Independence** Date signed **1/9/42**

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

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APR 18 1949

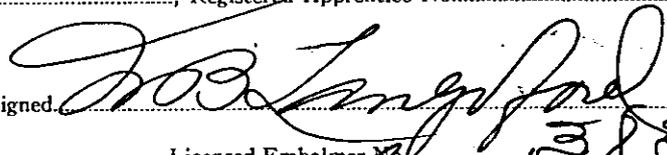
STATEMENT BY LICENSED EMBALMER

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.

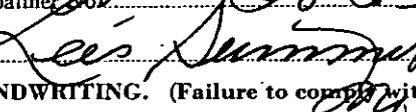
Signed



Licensed Embalmer No.

3883

P. O. Address.....



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.