

FILED OCT 20 1942

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3668

48  
3  
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days  
(Specify whether years, months or days)

In this community 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. Helping Hand Institute  
(If rural, give location)

(e) Citizen of foreign country, 523 Grand (Yes or No) 0  
If yes, name country

3. (a) PRINT GEORGE BRASHEARS  
FULL NAME

3. (b) If veteran, name war ----

3. (c) Social Security No. none

4. Sex M. 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife unk

6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased Dec. 7th 1873  
(Month) (Day) (Year)

8. AGE:

| Years     | Months   | Days     | If less than one day |
|-----------|----------|----------|----------------------|
| <u>68</u> | <u>8</u> | <u>7</u> | hr. min.             |

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

10. Usual occupation None

11. Industry or business

12. Name George Brashears

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

14. Maiden name No record

15. Birthplace No record  
(City, town, or county) (State or foreign country)

16. (a) Informant Record clerk

(b) Address K.C. General Hospital

17. (a) Burial (b) Date thereof Dec 9  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dec

18. (a) Signature of funeral director Wm. A. Robinson

(b) Address City mortician

19. (a) 10-6-42 (b) M. H. Crow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Monday August day 14th  
year 1942 hour 7 minute 55 A.M.M.

21. I hereby certify that I attended the deceased from 8-1-42 19..... to 8-14-42 19.....  
that I last saw him alive on 8-14-42 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchiectasis

Due to 106B

Due to

Other conditions None  
(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?

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

23. Signature Dr. R. Thom (M. D. or other) 0  
Address Med. Dir. K.C. Gen. Hospital Date signed

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**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.....

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.**