

S. No. 2
M-5-42
7-5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 11 1943
Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39581
State File No. _____
Registrar's No. 4878

Primary Registration District No. 1002

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: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 3 Days
In this community 18 Yrs.
years, months or days (Specify whether)

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. 67th. Ewing
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Oliver Morton Brown
3. (b) If veteran, name war. No. _____
3. (c) Social Security No. 495-01-2555

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 27
year 1942 hour 4 minute 20 A.M.

4. Sex male 5. Color or race Wh.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ida May Brown
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased April 20 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 22 1942, 1942 to Dec 27 1942,
that I last saw him alive on Dec 26 1942,
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
71 8 7 1/2 hr. min.

Immediate cause of death
Bronchial pneumonia terminal from arteriosclerosis
Due to arteriosclerosis
Duration 2 days
4 days
year

9. Birthplace Topeka Kansas
(City, town, or county) (State or foreign country)
10. Usual occupation watchman K.C. Public service

Other conditions (Include pregnancy within 3 months of death) 107

MOTHER FATHER
12. Name Jacob M. Brown
13. Birthplace Ind.
(City, town, or county) (State or foreign country)
14. Maiden name Emeline Mays
15. Birthplace Ind.
(City, town, or county) (State or foreign country)

Major findings: Of operations none
Of autopsy as above
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Ida May Brown
(b) Address 67th. Ewing
17. (a) Burial (b) Date thereof Dec. 29-42
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Memorial Park
18. (a) Signature of funeral director Eylar Funeral Home
(b) Address 1800 Linwood K.C. Mo.
19. (a) 12-29-42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature John D. Brown (M. D. or other) MD
Address 1140 1/2 E. 10th St. P.O. Date signed 12-28-42

1921 MAR 11 11:19

Dr. J. A. Skam...

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..... *Chas. Wilks*

Licensed Embalmer No. *2644*

P. O. Address. *1800 Linwood*

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.