

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 1116

Registration District No. 1002

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:
112 N. Topping
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 25 Years
years, months or days)

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. 112 N. Topping
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME BETTIE FRANCES BROWN
 3. (b) If veteran, name war No 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 4,
 year 1943, hour 11 minute 25 P.M.

4. Sex Fe. 5. Color or race White
 6. (a) Single, widowed, married, divorced, Widow
 6. (b) Name of husband or wife Marion
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept. 24, 1855
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-19-43 19____ to 3-4-43 19____
 that I last saw her alive on 3-4-43 19____
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
87 5 10 _____ hr. _____ min.

Immediate cause of death Chronic Heart failure
 Due to Hypertension, arteriosclerosis, heart disease
 Duration 2 week
 Due to _____ ? year

9. Birthplace Ky.
(City, town, or county) (State or foreign country)
 10. Usual occupation At Home
 11. Industry or business At Home

Other conditions (Include pregnancy, within 3 months of death) Calculus of Gallbl.
 12b 12b

MOTHER FATHER }
 12. Name Jacob Smith
 13. Birthplace Ky.
(City, town, or county) (State or foreign country)
 14. Maiden name Emma I. Smith
 15. Birthplace Ky.
(City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings: None
 Of operations _____
 Of autopsy None
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Fay Keith
 (b) Address 122 N. Topping
Removal
 17. (a) (Burial, cremation, or removal) _____ (b) Date thereof March 6, 1943
(Month) (Day) (Year)
 (c) Place: burial or cremation Chillicothe, Mo. Gen. Inc.
 18. (a) Signature of funeral director C.H. Blackman & Son, Inc.
 (b) Address Kansas City, Mo.
 19. (a) 3-5-43 (b) M. M. Cronin
(Date received local registrar) (Registrar's signature)

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 Thout B. Keith (M. D. or other) MD
 Address 924 Park Bldg Date signed 3-5-43

Dr. Lutz - Prof. Bldg.

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 *H. D. Blackman*
Licensed Embalmer No. *3639*
P. O. Address *N. 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.