

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37171  
State File No. \_\_\_\_\_  
Registrar's No. **4685**

**FILED NOV 19 1943**  
Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH: **Jackson**  
(a) County **Jackson**  
(b) City or town **Kansas City**  
(c) Name of hospital or institution: **1100 Park /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify, whether  
in this community \_\_\_\_\_ **unknown** (Yes or No)  
years, months or days)

2. USUAL RESIDENCE OF DECEASED: **48**  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(d) Street No. **1100 Park** (If rural, give location) **0**  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_ **0**

3. (a) PRINT FULL NAME **A.N. Brockston**  
3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Oct.** day **31st**  
year **1943** hour **2** minute **45 A.M.**

4. Sex **Male** 5. Color of **Col** 6. (a) Single, widowed, married, divorced. **Married**  
6. (b) Name of husband or wife **Mary Brockston** 6. (c) Age of husband or wife if alive **58** years  
7. Birth date of deceased **May 1877**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **9-28**, 19**43** to **10-31**, 19**43**  
that I last saw him alive on **10-31**, 19**43**  
and that death occurred on the date and hour stated above.

8. AGE: Years **66** Months **5** Days **0** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **MITRAL INSUFFICIENCY** **33 days**  
Duration

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

Due to **Arterio Sclerosis**

10. Usual occupation **Chef Cook**

Due to **92 hr**  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business **Unknown**

Major findings: Of operations \_\_\_\_\_

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

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? \_\_\_\_\_

16. (a) Informant **Mary Brockston**  
(b) Address **1100 Park**  
17. (a) **burial** (Burial, cremation, or removal) (b) Date thereof **11/5/43** (Month) (Day) (Year)  
(c) Place: burial or cremation **Lincoln Cemetery**

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **J. O. Honeig** (M. D. or other) **0**  
Address **1160 S. E. 18th St.** Date signed **11-3-43**

18. (a) Signature of funeral director **Hatkins Bros**  
(b) Address **1729 Lydia**  
19. (a) **11-5-43** (Date received local registrar) (b) **D. E. Bowen** (Registrar's signature)

**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.....

*J. J. Manlove*

Licensed Embalmer No. 3994

P. O. Address. 2673 Highland

**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.**