

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1263**

3
39
5871

FILED FEB 10 1944

Primary Registration District No. **1002**

Registrar's No. **411**

1. PLACE OF DEATH:
(a) County Missouri
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution about 2 weeks
In this community 6 years, (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson **48**
(c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL")
(d) Street No. 5163 Wornall Road **8**
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Emily Huffman Brown,
3. (b) If veteran, name war no. 3. (c) Social Security No. no.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 23rd year 1944 hour _____ minute 5: M.
21. I hereby certify that I attended the deceased from Jan 10 1944, to Jan 23 1944, that I last saw her alive on Jan 23 1944, and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Whitten H. Brown
6. (c) Age of husband or wife if alive X years 22 1865
7. Birth date of deceased September (Month) 22 (Day) 1865 (Year)

Immediate cause of death Hypertension
Myocardial Infarction
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years Months Days If less than one day
78 4 1 hr. _____ min.

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

10. Usual occupation at home

11. Industry or business X

12. Name William Huffman,

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

14. Maiden name Emily Huston,

15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Leo Collins,

(b) Address 5163 Wornall Road, Kansas City, Mo

17. (a) Removal (b) Date thereof 1-25-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dayton, Ohio,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, Kansas City, Mo

19. (a) Jan 25 1944 (b) 26 Brown
(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 0
23. Signature Fred Drury (M. D. or other) MD
Address 1610 Prof. Bldg Date signed 1-25-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Dr. Fred Dawing
Proff 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.....

E. M. Plank

Licensed Embalmer No.

1848

P. O. Address.....

74. C 210

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.

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 411

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

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

(d) Street No.....
(If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Mrs Emily Brown

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

3. (c) Social Security No.

4. Sex.....

5. Color or race.....

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

6. (b) Name of husband or wife.....

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

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b) E. Brown
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month Jan day 23
year 1944 hour..... minute..... M.

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

Immediate cause of death.....
Hypertensive Lobar
Pneumonia
Myocardial Exhaustion
Hypertension

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 6 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations.....

Of autopsy..... 108

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?.....

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

1263