

S. No. 2
M-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13577

State File No. _____

FILED MAY 1 1944

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1709

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: Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution one week
In this community 17 years (Specify whether 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. 5814 E. 22nd. St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____ # 0

3. (a) PRINT FULL NAME Senate Curtis Brown

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or face white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ruby Brown 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased April 21st, 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 11 26 _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business #

12. Name W.B. Brown

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

14. Maiden name Sally Roague

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

16. (a) Informant Mrs. Ruby Brown
(b) Address 5814 E. 22nd. St. K.C. Mo.

17. (a) Burial (b) Date thereof 4/19/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fayetteville, Mo.

18. (a) Signature of funeral director Earp Funeral Home

(b) Address 4139 E. 15th St. K.C. Mo.

19. (a) 4-18-44 (b) T. C. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 17 year 1944 hour 6 minute _____ P. M.

21. I hereby certify that I attended the deceased from 10 _____, 1944 to Apr 17 _____, 1944
that I last saw him alive on Apr 17 _____, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal uremia
Due to Chronic Nephritis

Due to Cerebral Hemorrhage
Other condition Cerebral Hemorrhage
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 1318

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? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Isaac J. J. J. (M. D. or other) _____
Address _____ Date signed 4/18/44

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

MOTHER FATHER

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. 29555

P. O. Address. H.C. 9th

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.