S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 1 1944

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 13578

Registrar's No. 1669

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: General Hospital #2. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4-11-44 - 1 hr. 25 min. (Specify whether
In this community 5 mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson 2

(c) City or town Kansas City 5
(If outside city or town limits, write "RURAL")

(d) Street No. 1717 Park
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME NERLINE BROWNE

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female

5. Color or race Negro 3

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased January (Month) 28 (Day) 1898 (Year)

8. AGE:

Years	Months	Days	If less than one day
46	2	~~14~~ 13	hr. min.

9. Birthplace Independence (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation maid

11. Industry or business

FATHER
12. Name Samuel S. Browne
13. Birthplace Booneville (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Fannie Ruffner
15. Birthplace Independence (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-15-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director E. Sterling Bills
(b) Address 1212 Vine St. R.C. Mo.

19. (a) 4-15-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 11
year 1944 hour 6:10 minute p. M.

21. I hereby certify that I attended the deceased from 4-11-44
4:45 p.m., 19__, to 6:10 p.m., 19__;
that I last saw her alive on April 11, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Same as above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

830

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 [illegible] (M. D. or other)
Address Gen. Hosp #2-600 E 22 Date signed 4-14-44

(Licensed Embalmer's Statement on Reverse Side)

444

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. Sterling Bills

Licensed Embalmer No. 3178

P. O. Address. 1212 Vine St.

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.

. S. No. 2B
M—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. 1669

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

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: K.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Gen. Hosp. #2.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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 Merline Browne.
3. (b) If veteran, name war
3. (c) Social Security No. 493-22-2505

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
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 4-15-44 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

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

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. .....

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

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 ..... (Specify whether year, months or days)

In this community .....

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 .....

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 .....

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

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

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

(b) Address .....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... 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 ..... Duration

Due to .....

Due to .....

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

Major findings:
Of operation .....

Of autopsy .....

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)

(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 .....

WHITE PLAINTY—USE INDIANA BLACK INK—MAKE A PERMANENT RECORD

S. No. 18
M—2-21-40
1 M2455