

U.S. No. 2
 FORM-5-43
 REV. 5-17-39
 X36671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **36632**
 Registrar's No. **4594**

FILED DEC 4 1944

Registration District No. **4194459**
 Primary Registration District No. **1002**

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

1. PLACE OF DEATH: **Jackson, Kansas City, Kansas**
 (a) County **Kansas City, Kansas**
 (b) City or town **Kansas**
 (c) Name of hospital or institution: **37 East 32nd Street**
 (If outside city or town limits, write "RURAL" and name of township)
 (d) Length of stay: In hospital or institution **10 days**
 In this community **40 years in K. C.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson, MO**
 (c) City or town **Kansas**
 (d) Street No. **37 East 32nd Street,**
 (e) Citizen of foreign country? **no.** (Yes or No)
 If yes, name country **x**

3. (a) PRINT FULL NAME **Dr. Hally Vidal Brockett**
 3. (b) If veteran, name war **no.**
 3. (c) Social Security No. **no.**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **November** day **13th**, year **1944** hour **5:30** minute **P.** M.

4. Sex **Male**
 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Mrs. Reba Brockett**
 6. (c) Age of husband or wife if alive **unknown** years
 7. Birth date of deceased **October 28 1885**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1928** to **11-13 1944**
 that I last saw **h.s.** alive on **11-13 1944**
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	59	0	15	hr. min.

Immediate cause of death **Coronary occlusion**
Hypertension and general arteriosclerosis
 Other conditions (Include pregnancy within 3 months of death) **94a**
 Major findings: Of operations **above**

9. Birthplace **Iowa,** (City, town, or county) (State or foreign country)
 10. Usual occupation **Oral Surgeon**
 11. Industry or business **x**

Duration **11-13 1944**
 PHYSICIAN **94a**
 Underline the cause to which death should be charged statistically.

MOTHER FATHER {
 12. Name **Dr. Frank L. Brockett,**
 13. Birthplace **unknown,**
 14. Maiden name **Sophia Vidal**
 15. Birthplace **unknown,**

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? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant **Mrs. Reba Brockett,**
 (b) Address **37 East 32nd St., Kansas City, Mo.**
 17. (a) **burial** (b) Date thereof **11-14-44**
 (c) Place: burial or cremation **not - Washington**

While at work _____ (Specify type of place)
 23. Signature **D. B. Smith** (M. D. or other)
 Address **1500 22nd** Date signed **11/14/44**

18. (a) Signature of funeral director **Stine & McClure,**
 (b) Address **3235 Gillham Plaza, K. C., Mo.**
 19. (a) **11-15-44** (b) **N. E. Brown**
 (Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

Dr. Don Black

Prof. Black & R.M.

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.....

Robert H. Reed

Licensed Embalmer No. *3745*

P. O. Address *Kansas City 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.