

FILED JUN 1 1945
149

Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH: **Jackson**

(a) County **Kansas City**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **General Hospital #2**
(d) Length of stay: In hospital or institution **5-7-45-3-12-45**
In this community **35 Yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **1027 Troost**
(e) Citizen of foreign country? **NO**

3. (a) PRINT FULL NAME **WILLIAM BROWN**

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

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **1874**
7. Birth date of deceased **May 5 1874**

8. AGE: Years **71** Months **0** Days **7** If less than one day hr. min.

9. Birthplace **Ray County Missouri**

10. Usual occupation **Laborer**

11. Industry or business _____

12. Name **Bob Brown**
13. Birthplace **Unknown**
14. Maiden name **Nancy**
15. Birthplace **Unknown**

16. (a) Informant **Record Clerk**
(b) Address **Gen. Hosp. #2**

17. (a) **Burial** (b) Date thereof **5-19-45**

(c) Place: burial or cremation **Highland Cem.**

18. (a) Signature of funeral director **G. E. Davis**

(b) Address **Chapellepiedra, Mo.**

19. (a) **5-19-45** (b) **Sheraldine Holmes**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **12**
year **1945** hour **10:00** minute **A**

21. I hereby certify that I attended the deceased from **May 7 45** to **May 12 45**
that I last saw him alive on **May 12 45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Stomach**

Due to **Carcinoma of Stomach**

Due to _____

Other conditions **46 1/2**

Major findings: Of operations _____
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

- While at work? _____ (Specify means of injury)

23. Signature **G. E. Davis** (M. D. or other) _____
Address **Gen. Hosp. #2 - 600 E. 22** Date signed **5-14-45**

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 L. G. Harris Sr.

Licensed Embalmer No. 3398

P. O. Address 12 E. 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.