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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 21 1946

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 11

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: BRINDERS HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8-DAYS (Specify whether)

In this community 40 YEARS  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON <sup>48</sup>

(c) City or town KANSAS CITY <sup>3</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 3914 WYOMING STREET <sup>8</sup>  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) <sup>1</sup>

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. ELIZABETH SUE BRODRICK

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 3<sup>RD</sup>  
year 1946 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from Monday  
1 / 1 1946 to Jan 2 1946 and  
that I last saw her alive on Jan 2, 1946  
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 MR. ERVIN BRODRICK

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

7. Birth date of deceased MAY 12 1860  
(Month) (Day) (Year)

Immediate cause of death Myocardial Infarction

Due to Cerebral Hemorrhage 2 weeks

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day

85 | 7 | 22 1/2 hr. min.

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

10. Usual occupation AT HOME

Major findings: 92%

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name WILLIAM CATRON

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

14. Maiden name ELIZABETH WARD

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

16. (a) Informant MR. LE ROY WHITE

(b) Address 3644 SUMMIT STREET

17. (a) BURIAL (b) Date thereof JAN-3-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. WASHINGTON CEM.

18. (a) Signature of funeral director D.H. Newberry

(b) Address 1401 BRUSH GREEN BLD.

19. (a) 1-3-46 (b) Seraldine Holmes  
(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? \_\_\_\_\_

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury 0

23. Signature Carl Jackson (M. D. or \_\_\_\_\_)

Address 103 E. 1st Date signed 1-3-46

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

859

1103 East Main

**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 *H. C. Newcomer Jr*  
Licensed Embalmer No. 4043  
P. O. Address *R. C. 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.**