

FILED JUL 15 1946

Registration District No. 149

Primary Registration District No. 1002

2909

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:  
15th. and Harrison Streets  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 24 years  
(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. 1421 Lydia  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mack Brown

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Cleo Brown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased November - 7 - 1899  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
46 7 23 hr. min.

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

10. Usual occupation Plumbers helper

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

12. Name Mack Brown

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

14. Maiden name Mary Robinson (State or foreign country)

15. Birthplace Ft. Smith Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant Omer Brown

(b) Address 1115 S. 4th. St., Ft. Smith, Ark.

17. (a) Removal (b) Date thereof 7/2/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ft. Smith, Ark.

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

(b) Address 1212 Vane St., Kansas City, Mo.

19. (a) 7-2-46 (b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29  
year 1946 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
Deputy Coroner 19 \_\_\_\_\_  
that I last saw him/her alive on \_\_\_\_\_ 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to Fracture of Base of Skull

Due to Auto - Street Bus + pedestrian

Other conditions Same as above  
(Include pregnancy within 3 months of death)

Major findings: Of operations 1700-8 Of autopsy no-post  
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) Accident 123

(b) Date of occurrence 6-29-46

(c) Where did injury occur? K.C. Jackson - Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
15th & Harrison St.  
While at work? No (Specify type of place) (e) Means of injury Deputy Coroner

23. Signature W. J. Williams (M. D. or other) \_\_\_\_\_

Address 2636 - Broadway Date signed 7-2-46

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

MOTHER FATHER

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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.....

**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.**