

S. No. 2  
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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 23 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. 993  
Registrar's No. 94

Registration District No. 149

Primary Registration District No. 1002

**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 No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)  
In this community 47 YRS.

**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. 3515 Lexington  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Albert <sup>SIDNEY</sup> Brown  
3. (b) If veteran, name war No 3. (c) Social Security No. 487-03-7907  
4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced SINGLE  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased MARCH 23 1878  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month Jan. day 7th  
year 1947 hour 3 minute A. M.  
21. I hereby certify that I attended the deceased from Jan. 4 1947 to Jan. 7 1947  
that I last saw him alive on Jan. 7 1947  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>9</u>	<u>14</u>	_____ hr. _____ min.

Immediate cause of death Primary bronchogenic carcinoma  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 47C  
Major findings: Of operations \_\_\_\_\_  
Of autopsy See above

9. Birthplace PLATTE Co. MO.  
(City, town, or county) (State or foreign country)  
10. Usual occupation CERICAL WORK (RETIRED)  
11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name JOHN L. BROWN  
13. Birthplace KY.  
(City, town, or county) (State or foreign country)  
14. Maiden name ELLEN ANDERSON  
15. Birthplace DE KALB Co. MO.  
(City, town, or county) (State or foreign country)  
16. (a) Informant LINDA BROWN  
(b) Address 3515 LEXINGTON  
17. (a) BURIAL (b) Date thereof 1 9 47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation FOREST HILL  
18. (a) Signature of funeral director C.H. BLACKMAN & SON, INC.  
(b) Address KANSAS CITY, MO.  
19. (a) 1-9-47 (b) Thelma 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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature Wm W. Hart (M.D. or other) MA  
Address Med. Dir. Gen'l Hosp. Date signed \_\_\_\_\_

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

*Dr. Cope*

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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 *H. O. Blackman*.....

Licensed Embalmer No. *3639*.....

P. O. Address *14 E 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.**