No. 2
-1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 24 1947

Registration District No. 149

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38032

Primary Registration District No. 1002

Registrar's No. 4592

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: SHEA NURSING HOME 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 years (Specify whether years, months or days)
In this community: 11 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State: KANSAS (b) County: LYNN 999
(c) City or town: PRESCOTT 14
(If outside city or town limits, write "RURAL") 0
(d) Street No.:
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: 4

3. (a) PRINT FULL NAME: BELLE MARIA BROGAN
3. (b) If veteran, name war: NO
3. (c) Social Security No.: NO
4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: WIDOWED
6. (b) Name of husband or wife: CHARLES L. BROGAN
6. (c) Age of husband or wife if alive: 29 years
7. Birth date of deceased: AUG (Month) 29 (Day) 1862 (Year)

8. AGE: Years 85 Months 2 Days 3 If less than one day: hr. min.

9. Birthplace: SPRINGFIELD (City, town, or county) ILLINOIS (State or foreign country)
10. Usual occupation: HOUSE WIFE
11. Industry or business: AT HOME
FATHER
12. Name: LITTLEFIELD
13. Birthplace: NEW YORK (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: MARY ANN BELL
15. Birthplace: SPRINGFIELD (City, town, or county) ILLINOIS (State or foreign country)
16. (a) Informant: MRS LEONA HUGHES
(b) Address: 7404 MAIN
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof: 11-4-47 (Month) (Day) (Year)
(c) Place: burial or cremation: FORT SCOTT, KANSAS EVERGREEN CEMETERY
18. (a) Signature of funeral director: D.W. Newcomer Son
(b) Address: 1401 Brush Creek Blvd
19. (a) 11-3-47 (Date received local registrar) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 2 year 1947 hour 3:10 minute A M

21. I hereby certify that I attended the deceased from 10-25-47, 19..., to 11-2, 19 47 that I last saw her alive on 11-1, 19 47 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
(1) Hypostatic pneumonia	
fracture right femur	9 days
(2) senility	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: NONE	
Of autopsy	

PHYSICIAN
Underline the cause of 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: 10/25/47
(c) Where did injury occur? Kansas City (City or town) Jackson (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? convalescent home (Specify type of place)
While at work? no (e) Means of injury: fall

23. Signature: James H. O'Neil (M. D.)
Address: 825 Shubert Bldg Date signed: 11/8/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

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 D. A. Nofsinger

Licensed Embalmer No. 5938

P. O. Address Kansas City, M

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.