

No. 2
-5-43
17-39
X36671

Registration District No. 149 Primary Registration District No. 1002

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

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:
Goss May Rest Home 2800 E. 10th K.C. Mo.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 week
(Specify whether years, months or days)
 In this community 26 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City 3 "Rural"
(If outside city or town limits, write "RURAL")
 (d) Street No. 735 Hawthorne
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MR. THOMAS LEWIS BROWNING
 3. (b) If veteran, name war None 3. (c) Social Security No. None
 4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Effie M. Browning
 6. (c) Age of husband or wife if alive 63 years
 7. Birth date of deceased Nov. 24, 1881
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 27
 year 1947 hour 5:00 minute A M.
 21. I hereby certify that I attended the deceased from Dec 28, 1946, to Dec 27, 1947;
 that I last saw him alive on Dec 18, 1947;
 and that death occurred on the date and hour stated above.

Immediate cause of death Encephalomalacia Duration 10 mos
 Due to Cerebral Degeneration 1 yr
 Due to Cerebral Arteriosclerosis 1 yr
 Other conditions Extreme Cachexia
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: 730
 Of operations _____
 Of autopsy _____
 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) _____
 (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)
 (2) Means of injury 0
 23. Signature D. D. O'Leary M.D. (M. D. or other) _____
 Address 1229 Independence Ave Date signed 12-27-47

8. AGE: Years Months Days If less than one day
66 1 3 hr. min.
 9. Birthplace unknown, Ills. (City, town, or county) (State or foreign country)
 10. Usual occupation Retired Custodian
 11. Industry or business R.C. Mo. School Board
 MOTHER, FATHER { 12. Name John W. Browning
 13. Birthplace unknown (City, town, or county) (State or foreign country)
 14. Maiden name Illnoes Innan
 15. Birthplace unknown, Ills. (City, town, or county) (State or foreign country)
 16. (a) Informant Mrs. Effie M. Browning
 (b) Address 735 Hawthorne
 17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12/29/47 (Month) (Day) (Year)
 (c) Place: burial or cremation Floral Hills
 18. (a) Signature of funeral director Geo. C. Carson
 (b) Address Independence, Mo.
 19. (a) 12-29-47 (Date received local registrar) (b) Sheraldine Holmes (Registrar's signature)

R.C. Smo

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..... *R.A. Lisle*

Licensed Embalmer No. *4123*

P. O. Address *Independence, 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.