

S. No. 2  
K-1747  
1-17-39

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **12438**

**FILED APR 17 1948**  
Registration District No. **1002**

Primary Registration District No. **1002**

Registrar's No. **1270**

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

In this community **42 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. **411 West 14th Street**  
(If rural, give location)

(e) Citizen of foreign country? **no.** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **John W. Brown**

3. (b) If veteran, name war **No.**

3. (c) Social Security No. **496-10-6186**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **26**  
year **1948** hour **5** minute **35 P.M.**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Nellie D. Brown**

6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased: **9 26 1871**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 23** 19**48** to **March 26** 19**48**;  
that I last saw him alive on **March 26** 19**48**;  
and that death occurred on the date and hour stated above.

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

**76 6 0** hr. min

Immediate cause of death: **Cerebral hemorrhage**

Due to: **arteriosclerosis**

9. Birthplace: **Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **General Contractor**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **832**

Of operations

Of autopsy **None**

11. Industry or business

12. Name **John Wooden Brown**

13. Birthplace **Illinois**  
(City, town, or county) (State or foreign country)

14. Maiden name **No Record**

15. Birthplace **Pt. Wayne**  
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause of which death should be charged statistically.

16. (a) Informant **John Wooden Brown Jr.**

(b) Address **2730 Troost**

17. (a) **Burial** (b) Date thereof **3-29-1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Washington**

18. (a) Signature of funeral director **Mrs. C.L. Forster**

(b) Address **Kansas City Missouri**

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)

19. (a) **3-27-48** (b) **Sheraldine Holmes**  
(Date received local registrar) (Registrar's signature)

23. Signature **Wm W. Hart** (M. D. or other) **MD**  
Address **Med. Dir. Gen'l Hosp** Date signed **3-27-48**

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

18  
8

48380

*Dr. Bruckstein*

**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 \_\_\_\_\_

*Jerry A. Minor*

Licensed Embalmer No. *4496*

P. O. Address *918 Brooklyn, K. 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.