

National Office of Vital Statistics

FILED JUL 19 1948

Registration District No. **1002**

Primary Registration District No. **1002**

Registrar's No. **2815**

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: **311 E. 70 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **50 YEARS**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **A. DOLPH BRENNER**
3. (b) If veteran, **no** name war **no**
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 **LILLIE**
6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased **3-15-1884**
(Month) (Day) (Year)

8. AGE: Years **app 64** Months **3** Days **23**
If less than one day hr. min.

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

10. Usual occupation **MERCHANT**

MOTHER FATHER
11. Industry or business
12. Name **MENDEL BRENNER U**
13. Birthplace **AUSTRIA**
(City, town, or county) (State or foreign country)
14. Maiden name **POSHA BRANDAS**
15. Birthplace **AUSTRIA**
(City, town, or county) (State or foreign country)

16. (a) Informant **DANIELL BRENNER**
(b) Address **311 E 70**
17. (a) **BURIAL** (b) Date thereof **7-9-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **MT CARMEL**

18. (a) Signature of funeral director **J. P. LOUIS FUNERAL HOME**
(b) Address **3400 WOODLAND AVE K.C. MO**
19. (a) **7-8-48** (b) **Walter Holness**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **JACKSON** **48**
(c) City or town **KANSAS CITY** **2**
(If outside city or town limits, write "RURAL") **8**
(d) Street No. **311 E. 70**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8**
year **1948** hour **7** minute **0** M.
21. I hereby certify that I attended the deceased from **1** July **1948**
that I last saw him alive on **1** July **1948**
and that death occurred on the date and hour stated above.
Duration

Immediate cause of death **Carcinoma of Lung**
Due to
Due to **Parkinson's Disease**
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: **478**
Of operations
Of autopsy

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) (Country) (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
23. Signature **W. H. Adams** (M.D. or other)
Address **306 E 12** Dr. (M.D. or other)

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.....

A. L. Lewis

Licensed Embalmer No.....

3110

P. O. Address.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2812

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:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether

In this community..... (Yes or No)
years, months or days)

3. (a) PRINT FULL NAME Adolph Brenner

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased March 15 1894
(Month) (Day) (Year)

8. AGE: Years 64 Months 3 Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 7-8-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 15 Year 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw him..... alive on....., 19....., and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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).....

(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..... (M. D. or other).....

Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MARK WITH RED PENCIL

SUPPLEMENTARY

S-23036