

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

20581

Registration District No. 1 1948

Primary Registration District No. 1002

Registrar's No. 3784

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City 4 mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Menorah Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7-14-48 (11:10 PM)  
9-15-48 (4:30 AM) (Specify whether  
in this community \_\_\_\_\_  
years, months or days) 4 Years

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. 350 East Armour  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Mrs La Setta O. Brown

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex M 5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife James H Brown

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Sept 14 1899  
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 1 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name John Martin

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

14. Maiden name Melinda Randolph

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

16. (a) Informant Robert W Brown

(b) Address 350 East Armour

17. (a) Removal Removal (b) Date thereof 9/17/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pawnee City, Neb

18. (a) Signature of funeral director Wmirk, Robin Co

(b) Address 20 West Linwood

19. (a) 9-16-48 (b) Heralding Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 9 day 15 year 48 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from 14, 1948, to 9-15, 1948.  
that I last saw her alive on 9-15, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Shock Duration \_\_\_\_\_

Due to Rupture of arteriosclerotic abdominal aorta & retro-peritoneal hemorrhage

Other conditions Generalized arteriosclerosis & myocardial hypertrophy

Major findings: Of operations \_\_\_\_\_

Of autopsy 96

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) (c) Means of injury \_\_\_\_\_

23. Signature Alvin Silver M.D. (M. D. or other) Address 1702 S.W. Persh, KCKS Date signed 9/15/48

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

MOTHER FATHER

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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 Howard W. Farmer .....

Licensed Embalmer No. 4134 .....

P. O. Address Kansas City 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.**